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BALCONY

the JOURNAL
OF THE MEDICAL SOCIETY OF NEW JERSEY

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VOL. 66, NO. 1

ANNUAL MEETING—May 17-20, 1969
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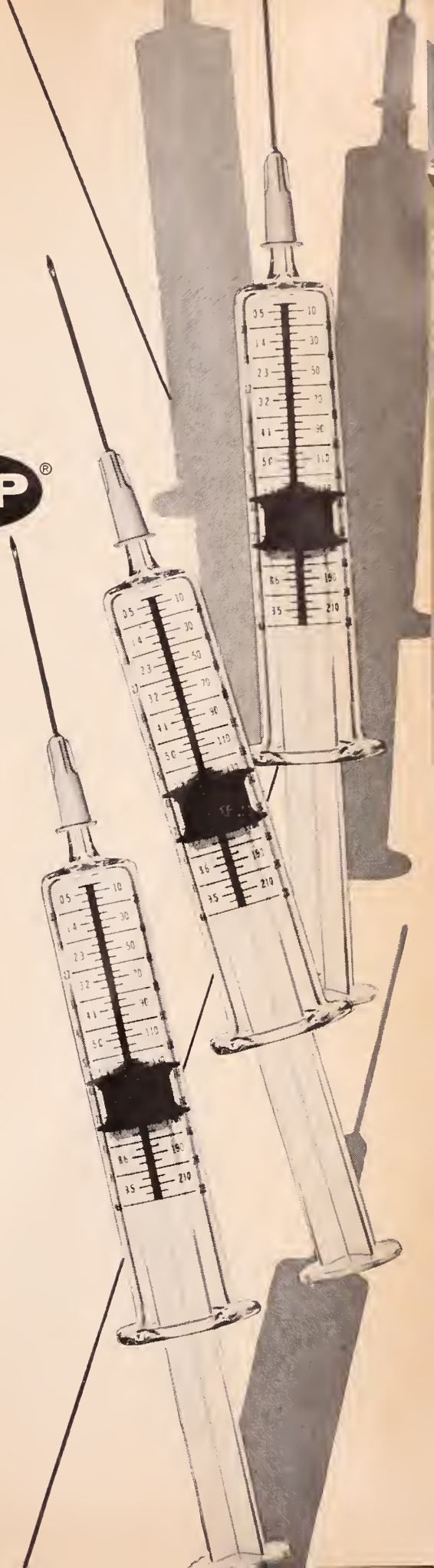
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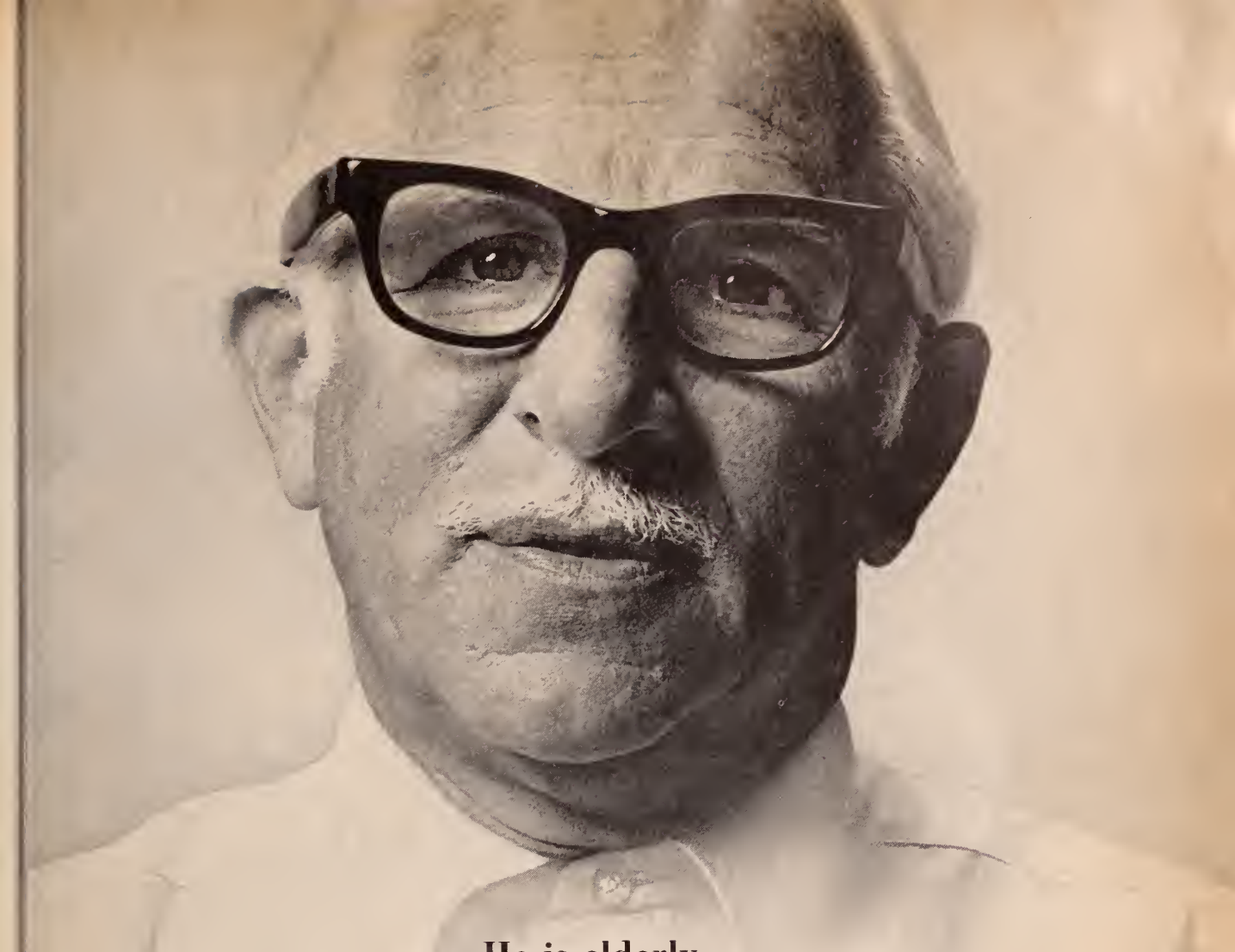
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ntraindication: History of hypersensitivity to demethylchlortetracye or nystatin.

rning: In renal impairment, usual doses may lead to excessive accumtion and liver toxicity. Under such conditions, lower than usual doses indicated, and, if therapy is prolonged, serum level determinations y be advisable. A photodynamic reaction to natural or artificial sunht has been observed. Small amounts of drug and short exposure may oduce an exaggerated sunburn reaction which may range from erytma to severe skin manifestations. In a smaller proportion, photoergic reactions have been reported. Patients should avoid direct posure to sunlight and discontinue drug at the first evidence of skin comfort. Necessary subsequent courses of treatment with tetracies should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

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Blue Shield
"Comprehensive Benefits" Program

TO THE MEMBERS OF THE MEDICAL SOCIETY OF NEW JERSEY:

A comprehensive benefit program for national accounts is being developed by the New Jersey Blue Shield Plan in conjunction with, and at the request of, the National Association of Blue Shield Plans. The purpose of the program is to make available a wider scope of benefits for large national accounts to choose from when they purchase their health benefit program; and, of course, the extended coverage will be paid for by an additional premium.

This program will be sold only to national accounts in conjunction with other Blue Shield Plans throughout the country. It will in no way replace or affect the Plan's basic programs. It will not be offered to local groups, nor to individual subscribers.

In New Jersey the principle additions to existing benefits will be the coverage of doctors's home and office visits and also special programs such as inhalation therapy and vision care.

The National Association of Blue Shield Plans has set a target date of April 1, 1969, for all Blue Shield Plans to offer the additional benefits, and while the New Jersey Blue Shield Plan, in conjunction with other Plans, is working toward this date, it is possible that because of actuarial problems involved in calculating rates for services not previously covered, the program may not be finally implemented until some time later.

In summary, the new benefits of the comprehensive benefit program, when available, will be offered only to large national accounts which wish to pay for these additional benefits. This program will not in any way affect any of the other Blue Shield programs.

It is hoped that the above will help to clarify any misapprehensions that may have arisen from some of the articles in the local press or national magazines.

Sincerely,

Joseph P. Donnelly M.D.

Joseph P. Donnelly, M.D.
President

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Dear Dr.

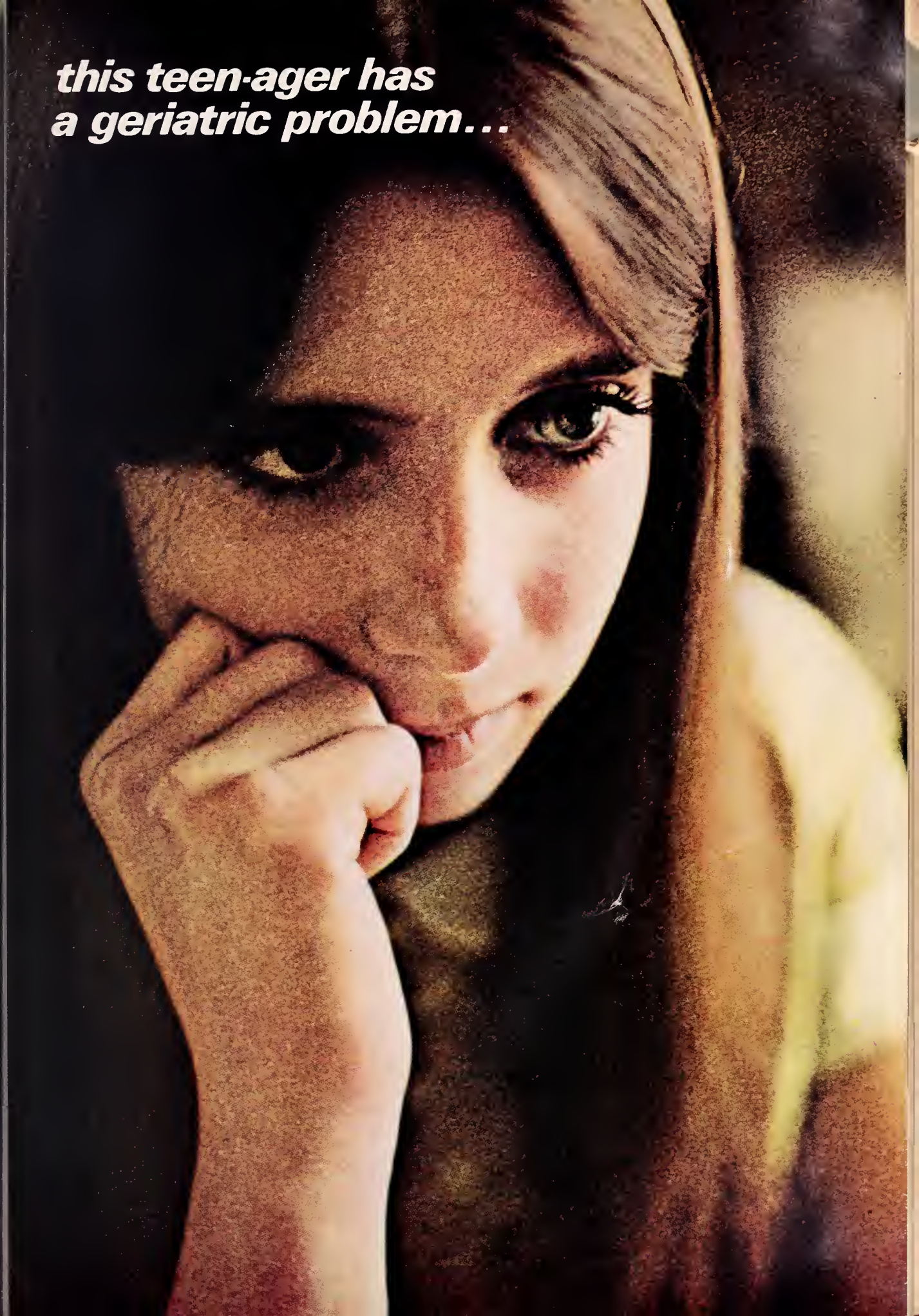
The familiar problem posed in the following three pages is not limited to a patient/physician relationship.

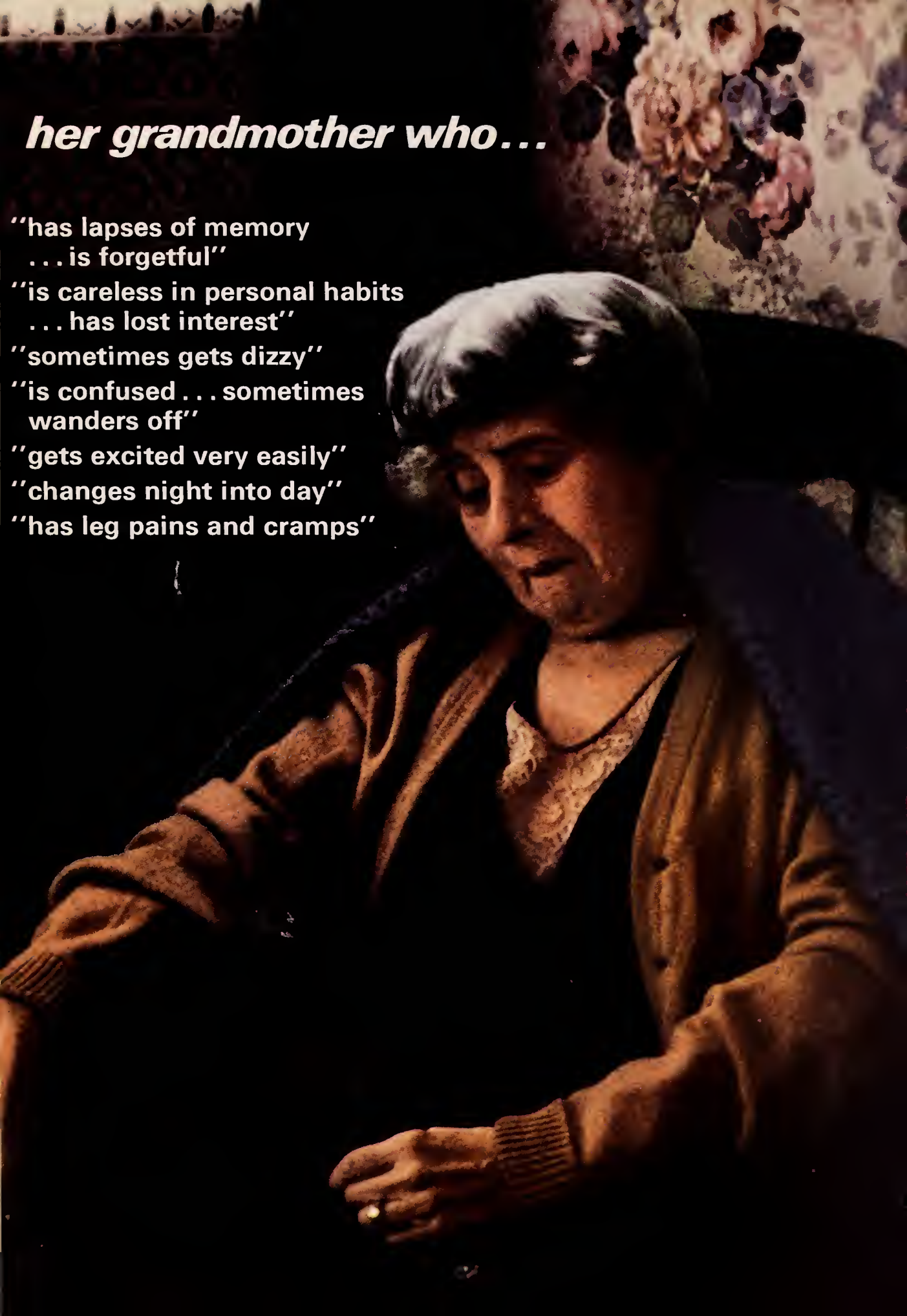
The headline (with an appropriate illustration change) very well could read, "This doctor has a geriatric problem"... if so Pavabid (papaverine H Cl. 150 mg) may help.

If such a problem exists in your immediate family with a father, mother, brother or sister, and you feel Pavabid may be of some help, we have a program that will allow you to meet the Pavabid needs of these persons for as long as the need exists. For more information, please write me personally or call me collect.

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P A Boyer, M.D.
Medical Director


this teen-ager has
a geriatric problem...


her grandmother who...
"has lapses of memory ... is forgetful"
"is careless in personal habits ... has lost interest"
"sometimes gets dizzy"
"is confused ... sometimes wanders off"
"gets excited very easily"
"changes night into day"
"has leg pains and cramps"

Relief of these symptoms of cerebral and peripheral vascular insufficiency may be "most gratifying" with a regimen of

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(papaverine HCl, 150 mg) b.i.d.
Prolonged action by microdialysis

LaBrecque[1] on Cerebral Ischemia
"Fully realizing the handicap of attempting to evaluate subjective responses, it was definitely concluded that papaverine hydrochloride (Pavabid) proved a valuable aid in the treatment of the mentally confused geriatric patient."

Dunlop[2] on Cerebral Ischemia
"Even in patients in whom the cause of symptoms is in doubt, papaverine (Pavabid) merits consideration as a therapeutic trial. The occasional favorable response in such instances is most gratifying."

Stern[3,4,5] on Peripheral Ischemia
Substantial relief of the symptoms typical of peripheral vascular disease was demonstrated in three double-blind, crossover studies covering 80 patients. A total of 73 patients reported mild, good and excellent symptom relief.

Dunlop[2] sums it up—
"With the return of memory function there was often noted an improvement in energy, ambition and desire to return to a productive life."

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1. LaBrecque, D. C.: Papaverine Hydrochloride as Therapy for Mentally Confused Geriatric Patients, Cur. Ther. Research *8*:106-109 (March) 1966.
2. Dunlop, E.: Chronic Cerebral Vascular Insufficiency Treated with Papaverine, J. Am. Geriatrics Soc. (Accepted for publication.)
3. Stern, F. H.: Papaverine in the treatment of Peripheral Vascular Disease, J. Am. Geriatrics Soc. *13*:815 (Sept.) 1965.
4. Stern, F. H.: Leg Cramps in Geriatric Diabetics with Peripheral Vascular Ischemia: Treatment, J. Am. Geriatrics Soc. *13*:609 (June) 1966.
5. Stern, F. H.: Further Evaluation of Papaverine for Peripheral Vascular Ischemia, J. Am. Geriatrics Soc. *15*:386-393, 1967.

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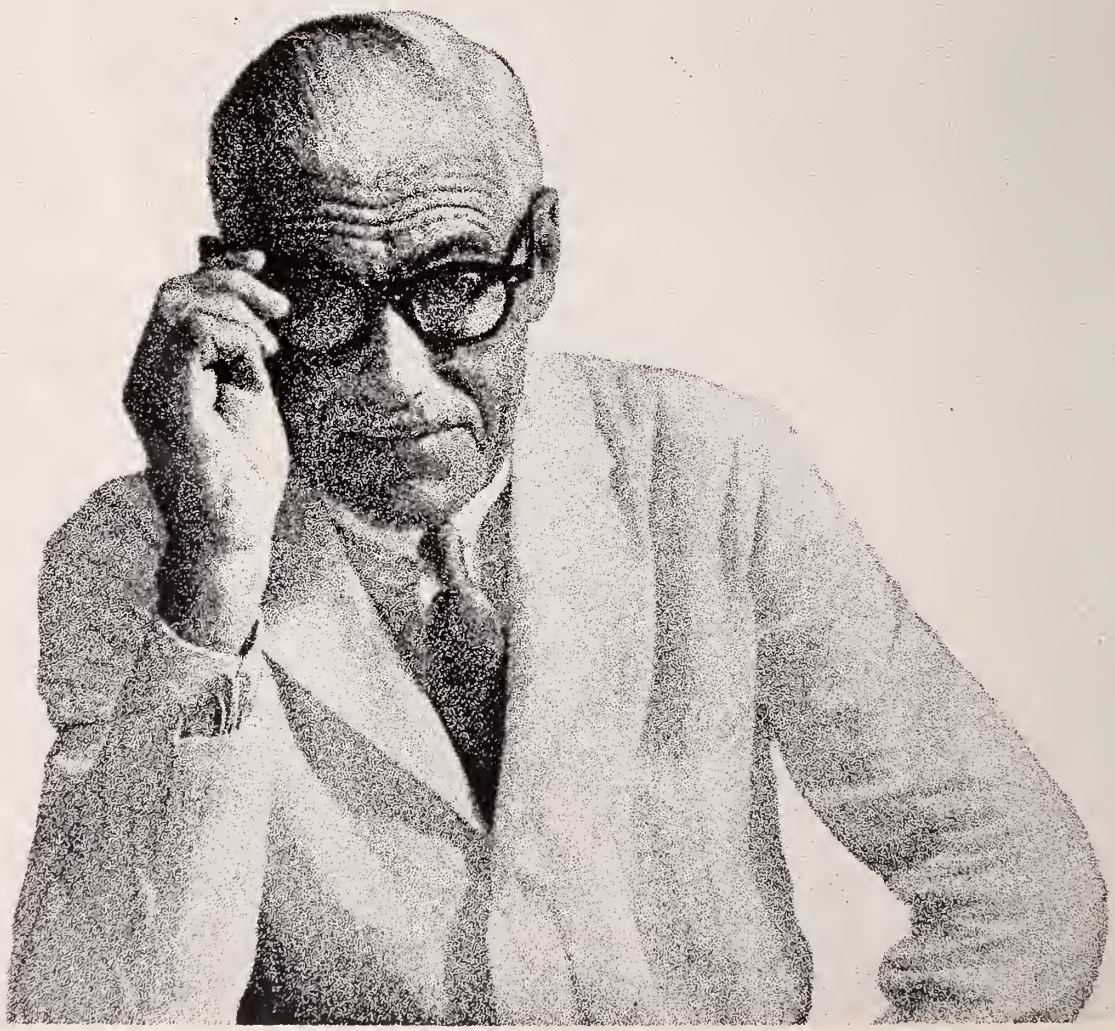
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IN BRIEF.

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Precautions: Keep out of reach of children. Not recommended for patients 12 years old or less. Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use of meprobamate in susceptible persons—as alcoholics, ex-addicts, severe psychoneurotics—has resulted in dependence or habituation. Withdraw gradually after prolonged excessive dosage to avoid possibly severe withdrawal reactions including epileptiform seizures. Warn patients of possible reduced alcohol tolerance, with resultant slowed reactions and impaired judgment and coordination. If drowsiness, ataxia or visual disturbances (impairment of accommodation and visual acuity) occur, reduce dose. If symptoms persist, patients should not operate machinery or drive. After meprobamate overdose, prompt sleep, reduction of blood pressure, pulse and respiratory rates to basal levels, and hyperventilation are reported. Give cautiously and in small amounts to patients with suicidal tendencies. Treat attempted suicide (has resulted in coma, shock, vasomotor and respiratory collapse and anuria) with gastric lavage and appropriate symptomatic therapy (CNS stimulants and pressor amines as indicated). Two instances of accidental or intentional significant overdosage with ethoheptazine and aspirin have been reported. These were accompanied by CNS depression (drowsiness and lightheadedness) but resulted in uneventful recovery. On basis of pharmacologic data, CNS stimulation could be anticipated, with nausea, vomiting and salicylate intoxication (requires induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, and observation for hypoprothrombinemic hemorrhage [usually requires whole blood transfusions]).

Adverse Reactions: Ethoheptazine and aspirin may cause nausea with or without vomiting and epigastric distress, in a small percentage of patients. Dizziness is rare at recommended dosage. Meprobamate may cause drowsiness, ataxia and rarely allergic or idiosyncratic reactions. These reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses. Such patients may have had no previous contact with meprobamate and may or may not have an allergic history. Mild reactions are characterized by urticarial or erythematous maculopapular rash. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. If allergic reaction occurs, discontinue meprobamate; do not reinstitute. Severe reactions, observed very rarely, include fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. These cases should be treated symptomatically including, when indicated, such medication as epinephrine, antihistamine and possibly hydrocortisone. A few cases of leukopenia, usually transient, have been reported on continuous use. Rarely, aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia have been reported, almost always in presence of known toxic agents.

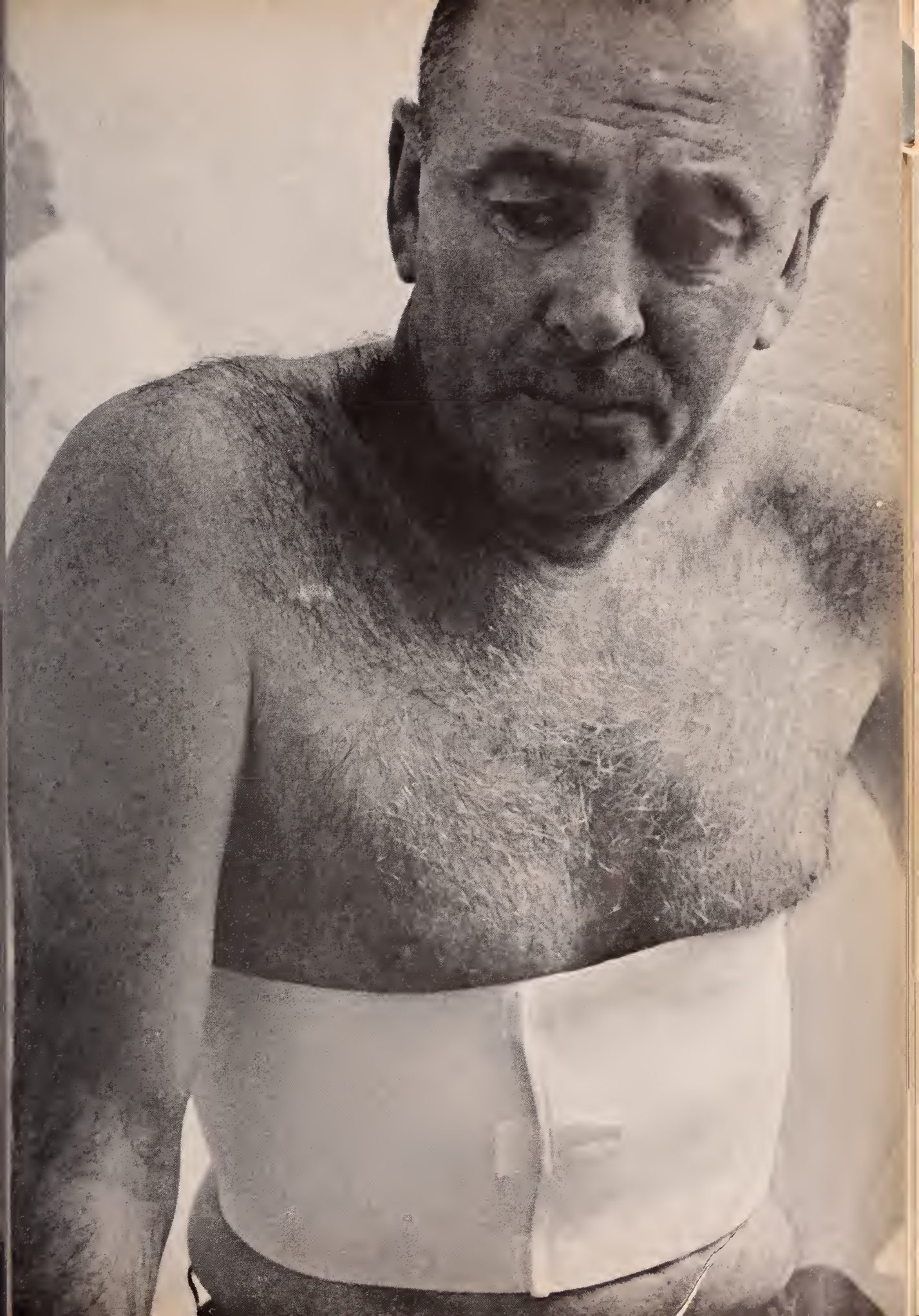
Overdosage: See precautions section for management of overdosage.

Composition: 150 mg. meprobamate, 75 mg. ethoheptazine citrate and 250 mg. aspirin per tablet.

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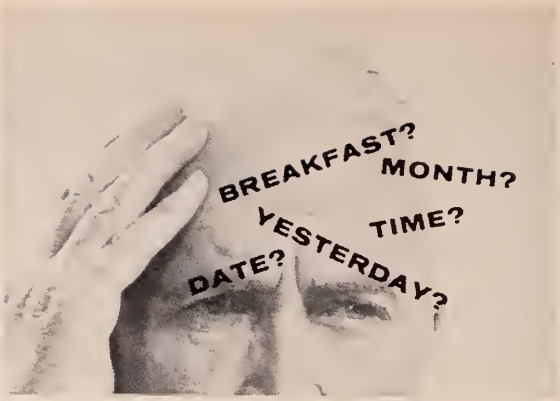
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Contraindications: Infections caused by nonsusceptible organisms; history of penicillin sensitivity.
Warnings: Acute anaphylaxis (may prove fatal unless promptly controlled) is rare but more frequent in patients with previous penicillin sensitivity, bronchial asthma or other allergies. Resuscitative (epinephrine, aminophylline, pressor amines) and supportive (antihistamines, methylprednisolone sodium succinate) drugs should be readily available. Other rare hypersensitivity reactions include nephropathy, hemolytic anemia, leucopenia and thrombocytopenia. In suspected hypersensitivity, evaluation of renal and hematopoietic systems is recommended.
Precautions: In suspected staphylococcal infections, perform proper laboratory studies including sensitivity tests. If overgrowth of nonsusceptible organisms occurs (constant observation is essential), discontinue penicillin and take appropriate measures. Whenever allergic reactions occur, withdraw penicillin unless condition being treated is considered life threatening and amenable only to penicillin. Penicillin may delay or prevent appearance of primary syphilitic lesions. Gonorrhea patients suspected of concurrent syphilis should be tested serologically for at least 3 months. When lesions of primary syphilis are suspected, dark-field examination should precede use of penicillin. Treat beta-hemolytic streptococcal infections with full therapeutic dosage for at least 10 days to prevent rheumatic fever or glomerulonephritis. In staphylococcal infections, perform surgery as indicated.
Adverse Reactions: (Penicillin has significant index of sensitization): Skin rashes, ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; serum sickness-like reactions, including chills, fever, edema, arthralgia and prostration. Severe and often fatal anaphylaxis has been reported (see "Warnings").
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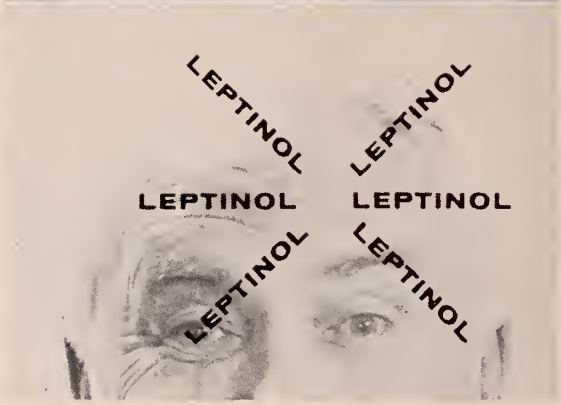
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Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation, have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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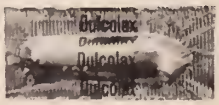
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Contraindication: Penicillin hypersensitivity.

Warnings: In rare instances, penicillin may cause acute anaphylaxis which may prove fatal unless promptly controlled. This type of reaction appears more frequently in patients with a history of sensitivity reactions to penicillin or with bronchial asthma or other allergies. Resuscitative drugs should be readily available. These include epinephrine and pressor drugs (as well as oxygen for inhalation) for immediate allergic manifestations and antihistamines and corticosteroids for delayed effects.

Precautions: Use cautiously, if at all, in a patient with a strongly positive history of allergy.

In prolonged therapy with penicillin, and particularly with high parenteral dosage schedules, frequent evaluation of the renal and hematopoietic systems is recommended.

In suspected staphylococcus infections, proper laboratory studies (including sensitivity tests) should be performed.

The use of penicillin may be associated with the overgrowth of penicillin-insensitive organisms. In such cases, discontinue administration and take appropriate measures.

Adverse Reactions: Although serious allergic reactions are much less common with oral penicillin than with intramuscular forms, manifestations of penicillin allergy may occur.

Penicillin is a substance of low toxicity, but it possesses a significant index of sensitization. The following hypersensitivity reactions have been reported: skin rashes ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; and reactions resembling serum sickness, including chills, fever, edema, arthralgia, and prostration. Severe and often fatal anaphylaxis has occurred (see Warnings). Hemolytic anemia, leukopenia, thrombocytopenia, and nephropathy are rarely observed side-effects and are usually associated with high parenteral dosage.

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EDITORIALS

M.D. As Part Of Your Name

It sometimes seems as if "M.D." is part of your name. Many physicians habitually sign themselves on the pattern of "John Smith, M.D." That's how they register in hotels, fill out forms, get their drivers' licenses, and so on. The matter seldom comes before the courts, but recently it did. A physician running for political office, wanted to be listed on the ballot as "John Doe, M.D." Here, the statutes provide that the "full name" of a candidate shall appear on the ballot. The candidate is a graduate with degree of Doctor of Medicine and is a licensed physician under the laws of Missouri. The election officials in preparing the ballot omitted the abreviation M.D., and the physician brought suit to compel the reinsertion of this abbreviation.

The physician testified that he is known by the name of John Doe, M.D., that the documents, legal instruments, and written communications which bore his name list him in this manner, that he always used this description.

The trial court* denied the physician's request, and the appellate court affirmed this denial.

The appellate court held that the conferring of a degree on the physician and his use of that degree after his name would not have the effect of changing his name. The initials M.D. were descriptive of his professional status. The court pointed out that the physician would in effect be placing his qualifications on the ballot by the addition of the initials "M.D." They added that this would require the election officials to permit other candidates to place on the ballot descriptive matters requested by them, encumbering the ballot and confusing the voter.

If the election officials were required to place M.D. after the name of the physician, then, at the insistence of other candidates, they would be required to place initials and descriptions such as "Atty.," "Rev.," "Dr.," "LL.B.," "A.B.," "B.S.," "Ph.D., "M.S.," "M.A.," "D.O.," "D.D.S.," and other descriptions which candidates may want on the ballot to show that they possess qualifications superior to those of their political opponents.

The appellate court rejected the physician's argument that he *must* use the designation M.D. because of the state statute requiring him to designate the degree to which he is entitled by reason of his diploma "in any letter, business card, advertisement, sign, or public listing or *display* of any nature whatsoever." This statutory requirement was thought by the court to prescribe conduct that is binding upon the physician only in matters that have connection with the practice of his profession. It was held *not* to be the intention of the legislature that a physician place the initials M.D. behind his name in every form of public listing. This is made clear by the provision that it is unprofessional for a physician to permit the use of his name under the designation of "Doctor," "Dr.," "M.D.," or "D.O.," or any similar designation with reference to the commercial exploitation of any goods, wares, or merchandise.

It's a nice point. The Missouri statute does require a licensed physician to designate his degree in "any . . . public listing . . ." and, surely a ballot is a public listing. (The Missouri appellate court didn't read it that way, but . . .) In a way, it may be a kind of arrogance, as if to plead for special consideration by reason of being an M.D. However, the "special consideration" often means an expectation that the doctor will be a good samaritan, stop and render aid at all accidents, go to the front of the stage when the manager calls out "is there a doctor in the house?", and respond to being flagged down by policemen or taxi drivers in order to deliver babies. The other doctors (the educa-

* Rainey V. Crow.

tions, psychologists, clergymen, and agronomists) don't seem to want *that* kind of recognition. So we can be pardoned for wanting to see the M.D. affixed.

Though you may have been a doctor much longer than you had been a mister (at least, if you're more than 50 years old), the M.D. really has not grown on to your name. It only seems that way.

The Patients They Deserve

Originally the priest was the physician and *vice versa*. Out of that joint heritage comes the concept of the sanctity of doctor's orders. For us, it is a convenient doctrine. Out of it comes the idea that you need not explain much to the patient. He's a layman and can't understand it. He's paying you for taking this concern off *his* shoulders and you must not put the burden on his back again. And anyway, no one cross-examines the priest as to the propriety of *his* instructions, so why cross-examine us?

And for generations, medical practitioners have been able to satisfy the public even though doctors had no cardiac pacemakers, electroencephalograms, dialysis machines, or penicillin.

Now we have the medically sophisticated patient who asks the practitioner "why" and the sophisticated instruments which require considerable technological skill and the sophisticated press which regales the public with self-taught brain surgery. This gives the physician a pair of alternatives. Either he develops patients who want to be told what to do and who ask no questions because doctor's orders are holy writ—either you get that kind of patient or you attract the inquiring kind who wants to see how the little pill falls apart in his stomach and coats the flame, just as they show it on television.

It is an open question whether it is the doctor's choice to develop the patient into an accepting and nonquestioning client, or to develop him into one who cross-examines. Do doctors train their patients, or do patients select the kind of doctor who suits them? Certainly the easiest system for the physician is to have passive, doctor-worshipping, incurious patients. There is, however, a gimmick. That kind of patient also wants to call up the practitioner at odd hours to get detailed advice, to ask all sorts of trivial questions, or to insist on a blue-print for living. All of which suggests that some physicians are indeed willing to be tormented by patients, and that private practitioners get the patients they deserve.

Self Criticism—Unlimited

Honest confession is good for the individual soul. But when a whole professional group wraps itself in sackcloth and ashes, it gets very confusing. As an over-reaction to the "doctor knows best" philosophy, many of our brethren, as well as many of our critics, have taken to writing of the evils of medical practice. There have also been articles on unnecessary surgery, exorbitant fees, reluctance to serve the indigent, and, of course, a veritable parade of polemics on the doctor's politics.

The unfortunate effect of all this well meant breast-baring is obvious. When we doctors participate in it, it may be due to our inherent masochism. But it is rationalized on the theory that this self-criticism shows how open-minded we are. In terms of the individual practitioner's prestige, this is not a healthy trend. And there is something even more important than our individual prestige. That is the patient's welfare. Here the net effect has been to make many people suspicious of the competency and motives of their doctors. For example, some gynecologists report an excessive amount of resistance to necessary pelvic surgery. This, they say, is due to garish publicity which has made many women feel that the operation may be medically unjustified. Similar examples of refusal to cooperate could be cited in every branch of medicine. Thus, this moan of *mea culpa* is not only damaging the doctor . . . what's worse, it's hurting the patient.

ORIGINAL ARTICLES

This is our JOURNAL's first venture into publishing a paper on the surgical aspects of skiing. New Jersey does have ski slopes, and skiers who go to Colorado or Switzerland do come home to be treated.

Background Of Ski Injuries

John R. Merendino, M.D. and Otto Lehmann, M.D./Long Branch

Skiing today is the most popular winter sport in the world. Four million skiers appeared on the slopes of the United States alone during the four month season in 1968. It is anticipated[7] that next year another 400,000 will join them. Skiing gives rise to a special form of trauma.

Evidence suggests that original skis were made from bones of large animals. In Stockholm, such a pair has been preserved. Skiing was used in the battle of Oslo between Norway and Sweden in 1200 and in 1483 by the Russians for military purposes. It wasn't until 1840 that Norwegians brought skiing to the United States,[5] although Leif Ericson and his party may have brought skis from Norway as early as A.D. 1000.

In 1851, John A. ("Snowshoe") Thompson came to California from Telemark, Norway and made skiing famous by carrying the mail on skis to the gold mining camps in the Sierra Nevada. The first races were held there in the 1860's and in the east the Manson Ski Club was organized in Berlin, New Hampshire. In Altoona, Pennsylvania, miners formed a ski club in 1885. In 1887 the first public ski jump tournament was held. One year later the Nordan Club of Ishpenning, Michigan held its tournament and tried to form a National Ski Association. Eleven clubs were then involved. In 1904, the Association was officially formed and the first National Ski Competition was held the following year.

The first Official Cross Country Race was held at Ashland, Wisconsin in 1907. Skiing was a sport which was now underway, but the Dartmouth Outing Club gets the credit for the early development of the down-hill slalom race. The Intercollegiate Sports Union was formed between 1923 and 1930. All forms of skiing developed rapidly as did the National Ski Association. The sport was greatly enhanced by the 1932 Olympic Winter Games held in Lake Placid, New York. In 1938, Woodstock, Vermont opened the first ski tow; the public was awake to the sport of skiing. This was the year when Minot Dole fractured his ankle on a New England ski slope. It took several hours and a painful trip by a crude sled before he reached a doctor. A friend who had helped him was killed only a few weeks later in a similar accident. Dole, so disappointed by the events, worked endlessly to organize the original ski patrol. In 1939 the Red Cross helped in the training of ski patrol members. After the beginning of World War II skiing was used in Europe for military purposes by the Tenth Mountain Infantry.

After World War II, skiing became the fastest growing sport in America. One major highlight was the successful hosting of the third Olympic Games at Squaw Valley, California in 1960. By then one and one half million people were skiing. Of these almost 75 per cent were considered "hard core" skiers. These ski an average of twelve days per year. Today the total number of skiers has been estimated at over four million with more than one half comprising "hard core" skiers. By

1970, this figure will increase by nearly another million.

Unlike other sports skiing is unique in the importance it has placed on the equipment. This is because better safety for the skier has always been of great concern. The earliest skis were strapped in place by a crude binding of hide. In 1868, Norheim of Norway introduced willow bindings to hold the skis in place. Subsequently Huitfield made a toe iron with a leather strap and buckle. In 1928, two revolutionary changes were introduced: the steel cable spring binding and metal edges. More recently metal skis with combined heel and toe releases have been introduced. Now, boot and ski are one unit whereas before they were held together by the toe.

The Alps (both in Switzerland and Austria) provide high mountains with many excellent trails and long runs. They also boast year round skiing, while skiing in the U.S.A. generally is only between late November and early April. Lately, snow machines have substantially extended the season. Eastern states have luxurious resort-style ski areas with the latest in ski lifts, such as: chair lifts, gondolas, poma-lifts, T-bars, and tows, (all of which, incidentally, caused injuries.) Eastern ski areas offer a combination of trails and open slope skiing. Western states advertise wide open trails and treeless slopes. Snow conditions are of considerable importance. The best snow is freshly packed, dry and non-sticky, occurring in cold weather. In contrast, bad conditions are found when the snow has thawed and again frozen to form ice; or when snow falls with the temperature just above the freezing point, to produce the "corn" or wet snow. Wind may blow snow from upper slopes, leaving bare rocks.

Skiing has evolved into a complex science requiring much coordination and stamina. In 1870, in Oslo (then called Christiania) Norheim jumped and stopped by placing one leg forward with weight on it, which could be internally rotated to produce a turn. This became known as the "Telemark" turn. He proceeded to develop a series of turns to control speed, the "Christiania" turns. In 1880, Zdarski of Austria (the "Father of Alpine Skiing") began to teach a fundamental turn used today by many beginners: the "Snow Plow" turn. The weight is placed on the outside or downhill ski as the skier internally rotates both legs.[3] In 1904, Schneider, at St. Anton on Arlberg, developed a modification in which only the outside (or "downhill") ski was internally rotated and the inside (or "uphill") ski could be picked up and placed alongside the downhill ski in a crouched position. He named this the Stemm Christiania (or "Stem Christie Seelos," in Austria). He realized that any upward movement of the body, as in jumping in the upright position, would take all the weight from the skis and then rotation from the hips could be used to rotate the skis together. This developed into the "Parallel" technic. The French perfected this method in their competitive skiing. It is the principal technic used today. Modifications of this include the "Wedeln," which is a series of rapid parallel turns using a continuous jumping motion. Recently the French have developed the "Mambo" technic, where the upper torso is rotated in the direction of the turn. This violent movement initiates the turn, and as the skis follow in pursuit, the torso is again quickly rotated but in the opposite direction to slow up or check the amount of turning of the skis.

The skier himself has undergone a marked change throughout the years. Originally he was a rugged worker of the mountains, then a soldier, and finally a sportsman. Even the sportsman has undergone a change. Before 1938, he was forced to climb the mountain he wished to ski, but the building of the first ski lift revolutionized skiing. Now the slopes were more enticing and one could downhill ski many times a day. The skier, however, lost his endurance and ruggedness. Soon people who had no ability for athletic endeavors were anxious to try their luck at skiing.

The typical skier today is between 23 and 30 years of age. His average income is between $8,000 and $10,000 a year.[7] Two-thirds are male and half of them are single. A quarter

are professional people. At least 40 per cent are college graduates. They spend between $18 and $20 a day while skiing, and their expenditure accounts are approximately $800,000,000 a year.[7]

With four million skiers the number of injuries has tremendously increased. In 1967, AMA studies[1] showed that chances of being injured in a day of skiing were about one out of 200. Howorth[3] reported 60,000 injuries per year for 1966. About 15 per cent are not seen on the slopes and go unrecorded. In a study by Ellison, Carroll, and Wolf[3] (in Vermont) half of the injuries occur in beginners and novices (even though they represent only a fourth of the total number of skiers.) Classes and organized groups have a much lower incidence. A class of 100 skiers who skied for three months had only two injuries; while at the same time and the same place, individual skiers had 5 lower extremity fractures. More recent studies show that the group with the peak age for the injuries is between 16 to 25 years.[7] This corresponds to a peak incidence in other sports injuries and auto injuries. This age bracket is in the "show-off age."

While only a third of skiers are female, they have almost half of the accidents. The rate of injury increases in those females who ski during the first and second day of the menstrual cycle. There is also a peak increase in incidence of married females[3] who do not like to ski, but, "came along for the ride." Incidence of injuries in skiers over 30, with five years of experience is very low.

Even though a physician does not live in a ski area, he is becoming involved with these injuries as people travel greater distances to their own physicians following an injury.

There are two basic groups of ski injuries. In the first, the skier strikes an obstacle or soft snow and the momentum carries him forward. If the bindings release, he most likely will not be hurt. If they do not release the motion is converted into an arc and the thrust is transmitted through the legs to the ankles. This leads to ruptures of the Achilles tendon and to Boot Top Fractures. In more technical terms a 150 pound person moving 30 miles per hour develops a momentum of 6,600 foot pounds per second. The same force could raise a 600 pound weight nine inches into the air. If he stops within two feet, the stopping force would be equal to 2,250 pounds or 15 times gravity. If he falls in such a way that the skis act as a lever, the force is greatly enhanced. If the skis do not become fixed to the ground he will fall end over end.

Energy is dissipated but there is a much greater chance of dislocation of the shoulder or spiral tibial fractures due to a force placed upon the ankle. This force has been calculated at 600 pounds on each leg. Even lacerations from the skis themselves have been reported[2] from this type of fall. The second group of injuries occur from turning accidents (rotational motion with torque) while the front of the skis are fixed and act as an axis, which amplifies the forces. In other words, the momentum formed from ski tip to the ankle is a factor of three feet. The momentum from the skier's center of gravity to the ankle is also three feet. Perpendicular forces are created, one of which gives an arc, while the other gives a torque which greatly increases the load placed upon the lower tibia.[2]

The snow plow turn and the stem turn make the skier prone to a fall when the skis cross. Traversing or crossing a slope can lead to a fall when the skier leans back or uses the wrong rotational force; or if his skis separate. Parallel turns are the safest, but complex weight movement and rotation can often lead to falling. When a skier falls using one of these technics it is usually due to the outside edge of the "downhill" ski catching or the inside edge of the "uphill" ski getting buried. The momentum carries the body downhill, but the ski tip is fixed and will not move when the free ski crosses over, and causes a fall. When turning on the fixed leg, there is a great torque on the tibia, creating a spiral fracture of the tibia and fibula and many knee injuries. The speed may well determine the distance of the fracture from the ankle. Appar-

ently the greater the speed, the further the fracture from the ankle. The slower speed, the shorter the distance. The ankle normally acts as a sheer pin. The malleoli break before the tibia, but while skiing, the boots cancel this effect and therefore this force is transmitted to the tibia itself.

Wolfe[1] has listed the following injuries as most common:

1. Boot top fractures, due to high speeds and falling on wet snow or seen in collisions.

2. Ruptured Achilles tendon, ascribed to high speed, and sudden deceleration.

3. Anterior dislocation of the shoulder is a seasonal injury seen mainly in January and February where there is little snow on the ground. It is an impaction type of injury where the loss of balance has caused the skier to fall.

4. Fractured clavicle has a similar cause.

5. Fractured wrist occurs with a fall on the outstretched arm while skiing.

6. Ski pole injuries are self induced when the poles and strap are in an improper position, or when the skier does not hold his pole to the side and behind him. One cause of dislocated thumb is when the ski pole is held in an improper manner and the stress is placed on the thumb.

7. Coccygeal fractures are seen chiefly in beginners who tend to fall backward on the ice.

8. Femoral neck fractures are also noted primarily in beginners.

9. Spiral tibial fractures are due to torsional forces.

10. Ankle injuries are probably the most common ones noted.

11. Knee injuries occur with and without meniscal and ligamentous tears.

Forty per cent of the injuries have been reported to be sprains. Thirty per cent of the fractures (of which 90 per cent are below the knee) will be lateral malleolar fractures; 5 per cent would be dislocations, 7 per cent are ligament and tendon tears, Achilles tendon most commonly. Of the leg fractures, which comprise 80 per cent, 44 per cent are ankle, and 19 per cent represent the entire lower leg other than at the sites mentioned above. Facial fractures comprise 6 per cent, and wrist fractures account for 3 per cent.[3]

Many other types of injuries are reported such as spleen, liver, eye, chest punctures, sciatic paralysis, dislocation of elbows and lacerations of tendons. Even a femoral artery laceration was reported when a ski edge ran over the victim.

Deaths have occurred when skiers impaled their skulls on trees. Two ruptured aortas were reported in the Olympics.

Indirect causes of injury include frost bite, pulmonary edema due to the high altitude, and alcohol which is commonly used on the slopes, especially in the east. The skier does not realize its hazards. Alcohol intake increases the heat loss, secondary to vaso-dilatation and exposure. The risk is therefore greatly enhanced. Reflexes are decreased but euphoria is great. The altitude enhances the effects and causes one to take unusual risks. Alcohol should be consumed, if at all, after the day is over. Yet a woman who skied safely all day, had two cocktails after skiing, was walking to dinner at the lodge, tripped and fell on the ice fracturing her hip. There are definite causes for ski injuries for which the skier himself is most often to blame. The "Schussbaumer," who rides until he crashes into an object will be more subject to injury than the true skier who strives to master technic and control.

Fatigue has been a factor related to injury in all sports for many years. Howorth[3] states that 50 per cent of injuries occur after 2:00 p.m. The peak is on Sunday afternoon. The rate is higher at noon time and again high late in the afternoon. One study shows a peak at 12 noon and again at 4 p.m., "when snow freezes." These have become known as the fatigue hours. Garrick[8] feels that not fatigue but the fact that there are more people skiing during these hours is responsible for the increased incidence of injuries. His figures show that half of injuries occur during the first two hours of skiing.[1] Reaction time does increase with fatigue, so that fatigue must be considered as of great influence on skiing injuries.

Another important factor is the equipment used. Many skiers rent or borrow their apparel.

Half of all injuries will be found among the non-owners of equipment. Poor fitting and faulty equipment are factors; so is the fact that it is usually the novice who rents.

Boots should be tight fitting using two or three pairs of socks so that the forces are transmitted to the skis and not the ankle, but care must be taken not to impair circulation. Previously toe binding releases were used resulting in an increase in Achilles ruptures and boot top fractures. Most recently bindings have acquired two types of releases: the sideward toe release and the forward heel release. These are adjusted to release when the force is too great.

Earle of Sun Valley, Idaho, feels that there is no great advantage in heel release since his findings show no difference in the incidence of boot top fractures after the advent of heel releases. The problem arises when the temperature changes and causes the bindings to freeze and the boots to swell when they become wet. Theoretically, one should adjust his bindings before each run. High boots should not be worn, if the feet are pronated. If there is a genu valgum, inner pads or wedges should be added to the boots. Also, safety straps on the skis themselves should be used to prevent runaway skis.[4]

Modern slopes are a vast improvement over the older trails. But with the great usage and skis criss-crossing, trails and ruts have formed into snowpiles known as "moguls." A skier may hit them and lose his balance, or get the tip of his ski caught and buried in the snow. When they become icy he may suddenly drop into a split or twist.[5]

False advertising of the trails and weather conditions is a real problem. This is more commonly seen in the east and is quite misleading to the unsuspecting skier and will often lead him to take chances.

In dealing with an injured skier, the National Ski Patrol has rendered invaluable service. It does not want skiing physicians to act as Good Samaritans. This gives a false sense of security since you cannot properly examine some one on the slope.

In the east, G. Osler, of New York, heads a project with Wolfe and Ellison of Mount Snow.[3] They have treated 750 skiers each season. They use special forms to keep accurate records. These can be obtained from the National Ski Patrol. The forms should be kept in emergency rooms and offices. The data so accumulated will help develop information on the 15 per cent who are not detained at the slopes and will lead to uniformity in the description and better management of injuries. Thus, 47 skiers were treated at Monmouth Medical Center during the 1967-1968 ski season.

One might gain the impression that the risks involved in skiing are overwhelming. Yet these injuries are definitely preventable. Conditioning is a most important factor. Fewer people today actually train for skiing than any other sport. Most people ski only two to three days a year and this makes them vulnerable. A program of vigorous hill walking, jogging, stair climbing, swimming, dancing, bicycling, and gymnastics is advised. Reconditioning after an injury is also most important. Actually with adequate preparation these risks can largely be eliminated.

The sense of physical accomplishment, the exchange of experiences about skiing, and most important the enjoyment of the beauty of the winter landscape far outweigh the risks.

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631 Morford Avenue

One way of solving the dilemma of where to amputate is suggested by the arteriographic determinations here outlined.

Arteriographic Determination Of A Safe Amputation Level*

William A. Dwyer, Jr., M.D./Paterson

Patients with actual, or impending, gangrene of the foot frequently present the surgeon with a difficult choice of operative procedures. Rob[1] has made a point of the value of arteriography as an aid in reaching such an operative decision and has indicated that arteriography has enabled him to perform successful below the knee amputations in certain cases.

In terms of both patient acceptance and ease of rehabilitation, the lowest possible amputation level is the most desirable. However, lower amputations are always fraught with the hazard of failure and consequent re-amputation, thus increasing both morbidity and mortality.

With the work of Rob[1] in mind, it seemed to me that arteriography was a very good screening tool for determining the level of blood supply to a limb. For those who were not candidates for reconstructive procedures, the existence of adequate blood supply at a particular level ought to indicate with reasonable certainty the site at which amputation of a given limb would heal.

However, very little work has been done on the development of criteria for the existence of "an adequate blood supply," although Haimovici[2] has developed a classification of the vascular defects of the lower limb vessels. This paper is an attempt to remedy this defect.

* From the Department of Surgery, St. Joseph's Hospital, Paterson.

Technic

In view of the paucity of data available, the first studies have been done on amputated limbs. In all, 25 limbs have been dissected after preliminary injection of opaque medium either in the form of a pre-operative arteriogram or the post-amputation injection of barium into the posterior tibial artery. As a result of these studies, the conclusion has been reached that it is virtually impossible not to visualize a patent vessel by injection of radiopaque dye from a point proximal to it.



Figure 1
"Slide-Through" Cassette holder

For this reason, a femoral percutaneous arteriogram has been used for the preoperative



Figure 2
Lead Shield lifted to show 1st cassette; 2nd cassette is in place under patient side

evaluation of all limbs in which a femoral pulse has been present. This has been done as an independent procedure, under one per cent local xylocaine anesthesia, on a special cassette holder for the three foot cassette, which has made it possible to take two consecutive films of the limb approximately 10 seconds apart with dye injection (a total of 45 cubic centimeters of 50 per cent Hypaque®) continuing throughout this time interval (see Figures 1 and 2.)



Figure 3
In this 1st exposure, dye has not yet reached the level of the knee



Figure 4
On the 2nd exposure 10 seconds later, the dye clearly outlines the patent collateral network around the knee. This patient healed a BK amputation

This second exposure has proved of considerable value in estimating vascularity below the knee (see Figures 3 and 4.)

A translumbar aortogram has been carried out on those patients without a palpable femoral pulse on the affected side. In this entire series, there has been no morbidity or mortality associated with the arteriography.

Clinical Material

With the exception of two cases of traumatic injury complicated by ischemic change, these patients are elderly and suffering from one or more of the triad found in this age group: diabetes mellitus, arteriosclerotic heart disease or other evidence of arteriosclerosis, or hypertension. Average age was 66.

In all, 44 limbs in 41 patients have been investigated clinically. Six were found to have sufficient blood supply to warrant surgery other than amputation. The remaining 35 patients (38 limbs) have been included in this series.

To neutralize the built-in bias of the investigator, and to avoid controversy with some of the surgeons involved, an effort has been made to separate the amputee group into two categories; (1) amputations at the level indicated by the arteriogram, and (2) amputations at the level indicated by clinical grounds alone regardless of the arteriographic findings.

The care given these patients both in the pre-and-postoperative phase is essentially the same for both categories.

Table 1
Amputations With Arteriographic Guidance

Amputation Level		*Re-amputation Level*
Toe, with bypass	1—1 failed	AK amputation
Toe	3—2 failed	BK amputation AK amputation
Transmetatarsal	2—0 failed	—
Syme	1—0 failed	—
Below Knee	5—0 failed	—
Above Knee	15—0 failed	(3 died in immediate postop. period)
TOTAL:	27—3 failed	

Results

Tables 1 and 2 list the results in each category. Table 3 lists the results after the operations in category 2 have been carried out at the level indicated by arteriogram.

Table 2
Amputations With Clinical Guidance Only

Amputation Level		
Endarterectomy with toe amputation	1—1 failed	Subsequent AK amputation
Toe	2—2 failed	BK amputation
Transmetatarsal	5—5 failed	3 AK amputations 2 BK amputations
Below Knee	3—3 failed	Subsequent AK amputation
TOTAL:	11–11 failed	

Several facts are immediately clear from these tables: first, in this type of patient (i.e., the elderly arteriosclerotic who may have a complicating diabetes and/or hypertension) it is difficult to judge a "safe" amputation level anywhere below the knee on clinical grounds alone, as evidenced by the failure rate in Table 2. Some of this failure is probably related to the patient's reluctance to undergo a higher amputation coupled with the surgeon's wish to "take the chance that the lower level might heal." This is particularly true of the transmetatarsal level.

Table 3
All Amputations At Arteriographic Level

		Result
Toe amputations	4—3 failed	2 AK amputations 1 BK amputation
Transmetatarsal	2—0 failed	
Syme	1—0 failed	
BK amputation	9—0 failed	
AK amputation	22—0 failed	
	38	

Second, it is possible to predict a "safe" level of amputation at the BK (below-knee) level with a high degree of accuracy. It is possible that this type of prediction could be extended

to the lower levels also, but the data available are not sufficient to warrant conclusions as to its significance.

Third, from this series an adequate set of criteria can be developed for use in the evaluation of limbs by arteriography prior to amputation.

In the experience with this series, the following criteria have been used to predict safe healing at the "below-knee" level:

1. A patent popliteal bifurcation with a good set of collateral vessels at the knee and upper third of the leg on the first film is evidence enough for a BK amputation, regardless of the co-existence of a femoral block.

2. These same findings on the second film alone make the case a borderline one. The balance is determined by the extensiveness of the collateral network.

3. In the absence of a collateral circulation below the knee on either film, with a co-existent femoral blockade, the patient is deemed unsuitable for anything but some form of above-knee amputation.

4. The presence of a patent posterior tibial alone and without collaterals is deemed insufficient evidence to warrant a BK amputation and an above-knee is advised.

Figures 3 and 4 show the arteriogram of a patient who underwent a successful BK amputation and illustrates these criteria. Note the extensive collateral circulation and the intact branching of the popliteal (although the takeoff of the anterior tibial is occluded.) Figure 5 illustrates a partial occlusion of the posterior tibial and patency of the personeal. The collateral network is very scanty. This patient also underwent a "below knee" amputation which failed to heal.

As can be seen from these tables, failure occurred only when the arteriographic level was employed at the toe level. At the BK level, accuracy was complete in this series.

Comment

With such a high degree of accuracy, this method seems to present a reasonable answer to the surgical dilemma posed by the elderly patient with ischemic limb changes, who is not a candidate for definitive arterial surgery. On the one hand, the surgeon is confronted with the patient's desire for the lowest possible amputation and the knowledge that the lower the level of amputation the greater the ease of rehabilitation and eventual self-sufficiency. On the other hand, the risk of morbidity and re-amputation should the first level fail to heal is not inconsiderable. With this method, the chance of healing at the "below knee" level can be established with very little doubt.



Figure 5

Almost complete occlusion of the posterior tibial is shown here with the personeal artery intact. There is practically no collateral network, despite a similar main vessel configuration, (see Fig. 4). This patient failed to heal a BK amputation.

Indications are that extension of this type of survey to the transmetatarsal level can be carried out, but more work on this phase is necessary before a final decision can be reached.

Summary

A safe, easily employed arteriographic method of predicting a low amputation level that will heal with reasonable certainty is described, together with the criteria developed in the course of its employment.

In all, 38 limbs in 35 patients have been evaluated by this method with better than 90 per cent correlation between the arteriographic prediction and the eventual clinical outcome.

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412 Park Avenue

Poison Control Materials

Such "harmless" household products as a bottle of furniture polish, a box of aspirin, or a can of drain cleaner, left within the reach of children, can result in a serious, if not fatal, accident. Of course, these products are valuable assets in our home — when used as directed — yet they present a danger no more remote than the unknowing grasp of a small child.

Dr. John J. Walsh, Director, Division of Direct Health Services, who administers the Public Health Service's poison control program, has cautioned: "Children under five years of age are forever exploring their environment. Parents are often unaware of the ingenuity, agility, and expanded mobility of their youngsters as they develop and grow. This carelessness on the part of adults is directly related to their lack of awareness of the potential hazards of these substances when not used as the manufacturer intended."

The Division's National Clearinghouse for Poison Control Centers, is working through some 2,500 community organizations and other groups, including several in foreign countries, and some 5,000 radio and 650 television stations. Available materials include the popular "Dennis The Menace Takes A Poke At Poison" booklet; a list of source materials on accidental poisoning; a program guide suggesting how your community can participate; and first aid hints for poisoning.

In its year-round efforts to combat accidental poisoning, the Clearinghouse provides the nation's 550 poison control centers with information on the toxicity and chemical constituents of thousands of commercial products.

Want more information? Write to the National Clearinghouse for Poison Control, U.S. Public Health Service, Washington, D.C. 20201.

A relatively new, but safe and swift diagnostic aid is now available: scintillation scanning.

Radioactive Lung Scanning In The Diagnosis Of Pulmonary Disease*

Joseph F. Inzinna, M.D./Jersey City

With the application of radioiodinated macroaggregated albumin, scintillation photoscanning of the lungs has become a reliable method for estimating pulmonary perfusion without risk or morbidity to the patient. Spirometic data are readily obtained by employing radioactive gases such as Xe and O for determination of relative ventilation in different regions of the lungs, but no photographic image that corresponds with actual anatomy is produced.[2 5] Ariel and his group[1] have used ceramic microspheres that were radiated with Yttrium which did produce an adequate perfusion image of the lungs, but these spheres remain trapped indefinitely in the peripheral lung arterioles.

Early investigators of macroaggregated albumin presumed that the material was concentrated in the lungs by phagocytosis and proteolytic enzymes, somewhat similar to the behavior of degraded albumin in the liver. However, it has been since shown that the particles lodge in the capillary bed of the lungs by strictly mechanical means. There they are fragmented by cellular bombardment, plasma erosion, and forward and backward movement until they become reduced in size or converted into shapes small enough to traverse the distal arteriolar capillary bed. They are then returned to the circulation and rapidly phagocytized by the reticuloendothelial system of the liver and spleen. Only then are the albumin particles digested by proteolytic enzymes and the I label set free to enter the general circulation.

The procedure followed at our institution is to administer a total of 300 microcuries IMAA, half in the supine and half in the prone positions to insure adequate filling of all the regions of the lungs including the apices. This is preceded by blocking the thyroid gland with Lugol's solution. Exposures are then begun immediately with a one minute localization film followed by anterior, posterior, and lateral views of both lungs. All views are necessary since some perfusion deficits are occasionally undetected by omitting one view or another; but the entire procedure can be completed in 20 minutes. With the thyroid blocked by previous administration of non-radioactive iodine, a urinary excretion of over 90 per cent of the injected dose occurs within 5 days. Total disappearance of radioactivity in the lungs occurs within 24 hours. The particle size of macroaggregated albumin should range between 5 and 100 micra since the diameter of the terminal arterioles of the lung average between 30 and 40 micra. Smaller particle sizes would yield increasing liver uptake with a corresponding decrease in lung removal efficiency, and larger particles would increase potential hazard unnecessarily. With the usual doses, it has been calculated that approximately 20 million of the total 280 billion capillary units are blocked. For this

*Read before the Section on Chest Diseases, Annual Meeting of The Medical Society of New Jersey, Atlantic City, May 20, 1968.

reason there is no measurable effect on the pulmonary hemodynamics.

The role of scintiphotoscanning of the lungs following intravenous injection of radioiodinated macroaggregated albumin then becomes obvious. It is particularly useful in the early detection of pulmonary embolism without infarction because routine chest x-ray films seldom reveal signs of segmental or even lobar ischemia. The diagnosis of massive pulmonary embolism is often difficult since other diseases such as myocardial infarction and pneumonia can give the same clinical findings. Now that new methods have been developed for treatment of this condition, such as the anticoagulant drugs, proteolytic agents, ligation or plication of the inferior vena cava, and pulmonary embolectomy, rapid and accurate diagnostic procedures are required. Lung scanning fulfills this role more simply than pulmonary arteriography which is time consuming and necessitates cardiac catheterization although the latter may always supplement the scan.

While the most useful application of lung scanning may be the early detection of pulmonary emboli, it can be extremely helpful in any condition where information concerning pulmonary vascularity is desired. Thus, correlation of perfusion scans with chest x-ray films can aid in the diagnosis of various parenchymal malignancies, cysts, bullae and abscesses which interrupt normal perfusion in a given area of lung.

Prognostication as to the usefulness in chemotherapy for tuberculosis can be made by assuming that adequate perfusion of the affected area will almost certainly cause a drug to effect a cure while poor perfusion suggests that only surgery will be successful. In fact, the perfusion scan could be of value in the selection of surgical cases while serial scans would provide information on the effectiveness of a surgical procedure. Emphysema, bronchiectasis, and other types of chronic lung disease could be aided by knowledge of regional perfusion.

Summary

Scintillation scanning of the lungs using radioiodinated macroaggregated albumin is a simple and safe method for determination of pulmonary perfusion. Its most useful application appears to be in the early detection of pulmonary emboli. Valuable information can be obtained in certain types of malignancies and other space occupying lesions, in various forms of chronic lung disease, and as a screening test when surgical procedures are contemplated. Serial scans to determine the effects of surgery or chemotherapy can also be done and the scan could always be supplemented by pulmonary arteriography.

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921 Bergen Avenue

Here's a new use for a new razor!

Skin Grafting And Excision*

Biopsy of Skin Lesions With A New Safety Razor Dermatome

Melvin I. Shoul, M.D./Boston

One minor mechanical change converts the Gillette® adjustable safety razor into a multipurpose instrument for cutting split thickness skin grafts, and for definitive excision-biopsy of certain benign superficial skin lesions. Some of these procedures previously required expensive hospital facilities or equipment; now, however, these procedures can be performed in the office or out-patient department using the adjustable razor dermatome, a simplified technic, and local anesthesia.

Prior publications[1,2] describe conversion of the standard nonadjustable Gillette safety razor from a home shaver into a precise surgical instrument. This early model razor dermatome required two or more razor blades. One unaltered razor blade cut the graft or biopsy; one or more additional razor blades, narrowed in width, served as shims or spacers when placed beneath the cutting blade. Double edged razor blades (each of which are four thousandths of an inch thick) were easily converted into shims by fracturing off the outer narrow beveled cutting edges in a bench vise. With one shim in place in this standard razor dermatome the surgeon could cut uniform sheets of split skin, 1½ inches wide, ten to twelve thousandths of an inch thick and of unlimited length. Each additional shim or spacer raised the cutting blade by four thousandths of an inch resulting in grafts of increased thickness.

The new adjustable dermatome described herein has distinct advantages in that need for the shim is eliminated and a greater range of skin thickness can be cut. This report describes construction of the new dermatome, method of use, and application to a variety of problems in patients.

Construction Of The Adjustable Razor Dermatome

A skin guard on each side of the Gillette adjustable safety razor protects the shaver from injury. Each guard is supported by one central and two end struts. On both sides of the razor, the central strut is easily cut out with a narrow metal file, leaving open slots.

The adjustable razor contains a spacing bar moved by a click stop dial. In home shaving turning the dial from numbers one to nine gives added blade edge exposure for tougher beards. In surgical use this spacer increases blade edge exposure to cut split thickness skin of increasing thickness at each higher click stop. This spacer serves nicely for thickness adjustment and eliminates need for a shim. Cutting out the central bar is the only mechanical change needed for this simplified razor dermatome. (Figure 1)

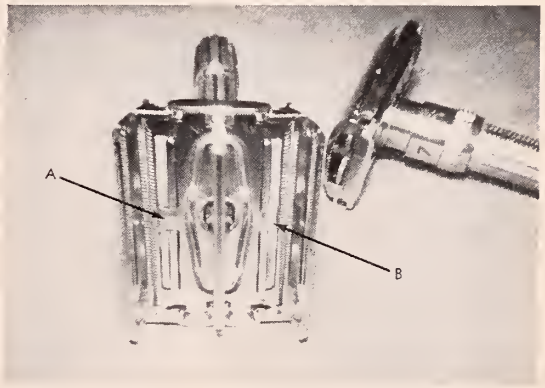


Figure 1.
Head end view of the open razor dermatome: The central supporting strut (A) should be filed out, as has already been done in (B), leaving an open slot through which the split thickness skin will protrude.

Prior to clinical use, animal experiments determined the precise thickness of skin cut at each click stop of the adjustable razor.

*Read before the Section on Dermatology, Annual Meeting, The Medical Society of New Jersey, Atlantic City, May 21, 1968. This work is from the Departments of Surgery at the Boston Beth Israel Hospital and the Harvard Medical School.

Laboratory Animal Technic

Full thickness strips of skin 2 inches by 4 inches were removed from fresh killed epilated guinea pigs. Using indelible ink a rubber stamp marked a 10 squares to the inch grid pattern on each strip. Each strip of skin was firmly tacked down to a cutting board. Using the technic described below, split thickness skin specimens were cut at each setting of the adjustable razor dermatome. Each split thickness skin specimen was then restored to its original dimensions by stretching the square graph pattern back to starting shape. Three off-the-shelf adjustable razors were used. At least three specimens of split thickness skin were cut at each setting with each razor. Every specimen was measured for thickness at both ends and in the middle.

Measurement of Skin Thickness

An engineering micrometer incorporates a movable spindle with vernier dial and a fixed base plate or anvil. Despite a spring ratchet arrangement (which prevented extreme tightening) these micrometers, designed to measure non-compressible substances, applied an excessive firm closing pressure. Our preliminary skin thickness measurements, using this type of micrometer, were, therefore, inaccurate and were discarded.

Mr. E. M. Lewiecki, of the Research Laboratory of The Gillette Safety Razor Company, designed and constructed a new skin micrometer (Figure 2). This instrument consists of a dial indicator, a through-the-dial spindle with a flat end contact plate, 2 square centimeters in area, and a weighted lever arm. A movable counterweight on this lever arm offsets a downward force of a similar weight on the spindle shaft. Adjustment of the counterweight outward reduces the resultant force applied to the flat end contact plate. This movable weight was adjusted outward to result in a five Gram per square centimeter force to the skin sample under measurement. At this low value skin samples were not compressed or indented. Measurements were reproducible.

Experimental results (Table 1) indicated a continuous range of split thickness skin cuts from .005 inch thick at setting number one to .023 inch thick at setting number nine. Following calibration, the adjustable razor

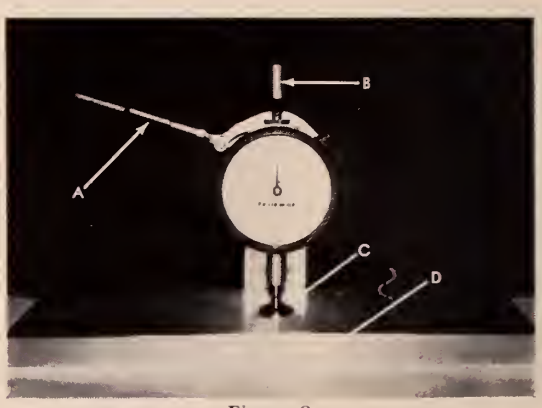


Figure 2.

Skin micrometer: A movable counterweight (A) on the lever arm offsets the downward weight of the through-the-dial spindle (B) so that the resultant force applied to the flat end plate (C) is 5 Grams per sq. cm. Skin samples to be measured are placed between the end plate (C) and the base (D).

was used in a variety of surgical and dermatologic problems.

Skin Grafting

A new stainless steel razor blade is equivalent in use to the sharpest, commercially prepared, dermatome blade. The thigh is the most suitable donor site. With this small instrument the surgeon can use other donor areas that are awkward to cut with the larger

ADJUSTABLE RAZOR DERMATOME

DIAL SETTING	THICKNESS (THOUSANDTHS)	AVERAGE (THOUSANDTHS)
1	4.5 - 6.0	6.0
2	7.0 - 9.0	8.0
3	8.0 - 9.5	9.0
4	9.5 - 12.0	11.0
5	12.0 - 14.0	13.0
6	13.5 - 16.0	15.0
7	15.5 - 17.0	16.0
8	18.0 - 20.0	19.0
9	20.0 - 23.0	21.0

Table 1.

Thickness of skin cut at each click stop of three off-the-shelf adjustable razors, suitably modified, was measured. Ten measurements were made at each stop of each razor. In clinical practice, the most useful settings were 1, 3, 5, 7 and 9.

dermatomes. Set the adjustable razor's dial prior to tightening the blade in place and according to thickness of skin desired (Table 1). The donor skin surface is infiltrated with procaine or lidocaine. Grossly concave surfaces can be raised by infiltration beneath the skin to give a smooth flat surface.

Before the operation, the starting edge of the donor site *must* be lubricated. A thin layer of sterile mineral oil is sufficient. Only the site of the initial incision needs to be lubricated; the subsequent small amounts of capillary bleeding maintain continued lubrication. Throughout the operation, the razor dermatome is held with its handle at a 45 to 60 degree angle against the donor's taut skin and is rapidly oscillated from side to side with approximately ½ inch displacement from its center position to each side. At the same time the razor is slowly pulled toward the operating surgeon. Throughout this procedure, the donor site must be held firmly and continuously on tension. Otherwise it will move with the oscillating dermatome, preventing enough slicing action to cut a uniform graft.

Correct hand pressure on the dermatome is equivalent to that applied to a scalpel when making an abdominal skin incision. Gentle pressure results in ineffectual scratches; the dermatome must bite the skin. Firm pressure at the start of the oscillatory motion insures the razor's entrance into the skin. Extreme pressure causes an undesired, slightly deeper skin cut. If the side to side motion is too slow, only small slivers will be cut rather than a neat, 1½ by 4 inch or longer quadrilateral piece. The cut skin graft appears crinkled or rolled up between the razor blade and the skin guard of the dermatome (Figure 3A). Scissors or scalpel is now used to free the one still attached end of the graft from its donor site (Figure 3B). The graft is now laid on the suitably prepared recipient area, firmly secured with a compression dressing consisting of a wad of cotton tailored to fit the wound and held in place with sutures crisscrossed over the top.

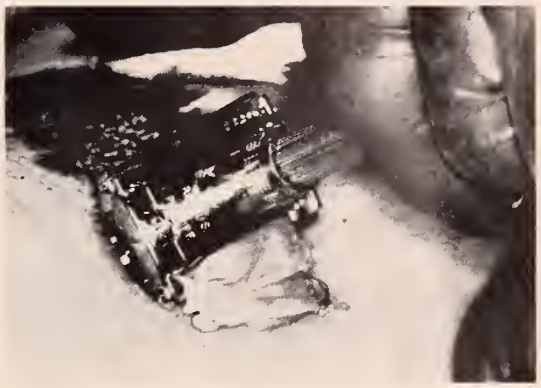


Figure 3A.



Figure 3B.

Razor dermatome in use: (A) The razor dermatome is held firmly against the donor skin, rapidly oscillated from side to side over a ½ inch radius and at the same time slowly pulled toward the surgeon. The cut skin graft appears curled up above the skin guard. (B) The cut graft is ready to be detached from the donor site.

Case 1

For six months a 70 year old man had noted a nonhealing skin lesion of the right forehead. He had a 10 by 14 millimeter ulcer with a raised rolled border. Biopsy was read as basal cell carcinoma. As a hospital out-patient procedure this tumor together with a one centimeter border of normal skin, was excised. The defect was covered with a razor dermatome split thickness graft .015 centimeters thick cut from the right thigh. Healing was prompt with a good cosmetic result. (Figures 4A, 4B)

Results With Skin Grafting

Razor dermatome grafts were used to cover defects in 100 patients. Half of the patients

had small basal cell or epidermoid carcinomas; the remainder had third degree burns, varicose ulcers, benign skin tumors and other skin problems.



Figure 4A.



Figure 4B.

(A) Basal cell carcinoma of right scalp. (B) Six weeks following excision and razor dermatome grafting, the graft is soft, smooth, and pliable.

In three patients, office skin grafting was used as an adjunct to a hospital procedure. One of this group (a fifty year old female) underwent left radical mastectomy for carcinoma. One week following operation a 3 by 7 centimeter area of the lateral skin flap was noted to be dusky and blue. She was discharged from the hospital with the understanding that if this questionable skin proved non-viable it would be excised and replaced with a razor dermatome graft. This area did slough, and was debrided. Two weeks later, following wet dressings at home, the defect was covered with a razor dermatome graft as an office procedure. Primary healing resulted. Two other patients with varicose ulcers had large skin grafts applied in the hospital. In each, a portion of the hospital applied graft, 25 millimeters in diameter and 30 millimeters in diameter, respectively, failed to take. As out-patient procedures, razor dermatome grafts were used to cover both residual defects. Good healing resulted.

Cosmetic results were generally as good as with use of other technics of skin grafting. Only one graft failed completely. In retrospect this had been placed on an inadequately prepared bed. Regrafting was successful.

Biopsy of Skin Lesions

Full thickness incisional biopsy of skin tumors suspected of being basal cell or epidermoid carcinomas is a standard technic. Any incision through a tumor, however, opens the possibility of transporting malignant cells to normal tissues deep to the neoplasm. In many instances a thin razor dermatome shaving from the lesion provides adequate biopsy and has the advantage of *not* contaminating subcutaneous tissue in the process.

Anesthetize the skin lesion by local infiltration around the tumor. Inject additional local anesthesia beneath the tumor to raise the local area above surrounding tissues. Set an adjustable razor dermatome to yield a thin cut. Click stop number 3 (which is .009 inch) is usually adequate. Using the above described method for skin grafts, shave off the top of the lesion for biopsy. Little pressure against the skin is needed. A biopsy of the junction of lesion with normal skin is most desirable. If the first slice is not representative, a second can be easily taken at the same time.

Case 2

A 47 year old female visited the office with a 15 millimeter ulcerated lesion of the right lower cheek. There was central depression with raised rolled edges. This obvious basal cell carcinoma was excised with a normal margin and the defect closed primarily. Two months later she pointed out a 3 millimeter crusted papule at the tip of the nose. Scalpel or punch biopsy was considered, but would probably have left a poor scar. Instead a razor dermatome biopsy was cut. Pathologic report was basal cell carcinoma. X-ray treatment yielded an excellent cosmetic result.

Ten patients had skin lesions biopsied with the razor dermatome. In one patient an unduly large amount of normal skin adjacent to the lesion was sliced off. Not enough local infiltration had been used to raise the lesion above surrounding skin.

Excision of Benign Lesions

Seborrheic keratoses, squamous papillomata, intradermal nevi, and other benign superficial skin lesions can, with the razor dermatome, be biopsed and excised at the same sitting. When used to excise surface skin lesions the razor dermatome acts as a sharp scalpel that cuts at a controlled level. The surgeon must elevate the lesion above surrounding normal skin and create a plateau the top of which can be shaved off in one or more slices.

Infiltration of saline or procaine beneath all parts of the lesion and a border of normal skin will create this elevated plateau. If the resulting surface has an uneven appearance, a few drops of infiltration fluid beneath the depressed areas will create a smooth surface. If, on the other hand, parts of the lesion have been elevated too high by subcutaneous injection, a few minutes' wait will allow absorption of the injected fluid and flattening of the skin surface. Xylocaine spreads evenly and smoothly, but other local anesthetics are adequate. After a few seconds wait to insure good local anesthesia, lubricant (sterile mineral oil) is applied and the lesion is sliced off. The technic is as described under skin grafting with one exception. The lesion has been raised: therefore much less downward hand pressure on the dermatome is needed here. Caution should be observed. It is better to cut a too thin slice rather than a too thick slice. If the entire lesion is not sliced off with the first pass of the razor dermatome, additional thinner slices are removed until normal tissue is reached. A non-adherent dressing is applied. In properly selected cases cosmetic results are superior to full thickness excision and suture.

Case 3

A 34 year old housewife sought removal of a brown-black pigmented "mole" of the left cheek. Her friends had often told her "there is a spot of dirt on your cheek." There had been no change over a ten year period.

The lesion (Figure 5), 10 by 14 millimeters in diameter, was slightly raised, finely granular in texture and appeared to be an intradermal nevus. Full thickness



Figure 5A.



Figure 5B.

Before operation. (A) An intradermal nevus of the left cheek, lateral to the left nostril. (B) Three weeks following shaving with the razor dermatome. The site of the former nevus is soft, smooth and nearly invisible.

elliptical excision and primary closure were considered, but this would have left a linear scar in a prominent position. Instead, the lesion was shaved down with two passes of the razor dermatome. The pathologist reported the lesion as an intradermal nevus. Within three weeks the area was smooth, pliable, and almost invisible.

Treatment of Hypertrophic Scars

Broad, bumpy, or otherwise unsightly hypertrophic scars following burns, traumatic injuries, or elective surgery can in some cases be shaved flat, using the razor dermatome with a cosmetic result superior to that anticipated with excision and primary closure. Infiltrate local anesthesia around and beneath the scars. Using the adjustable razor dermatome set at a low number, plane down elevated portions of the scar. If subcutaneous tissues are exposed, small defects can be left to epithelialize from adjacent skin. Larger areas can be effectively covered with a razor dermatome split thickness graft taken from adjacent skin.

Case 4

A 32 year old housewife, while pressing clothes, accidently dropped a steam iron on her left forearm. An 8 by 7 cm. deep second degree burn resulted. This was treated by the open method with prompt healing. Six months later, she complained that the scar was thick, nodular and leathery. It was a healed burn scar with the irregular surface characteristic of healed deep second degree burns. It seemed unwise to sacrifice this large area of functionally good skin, with graft substitution. Instead, under local anesthesia, the raised portions of the burned skin were sliced down level with the depressed portions of the scar. A few pin head sized areas of subcutaneous tissues were exposed while shaving down the most elevated portions. Healing was prompt. Although there was no improvement in color the patient was pleased that the new scar was soft, smooth and pliable.

Results of Excision biopsy

Fifteen patients had benign superficial skin lesions removed with the razor dermatome. In the initial patient it was not appreciated that less pressure and pull on the dermatome was needed, so that inadvertent superficial cuts were made in the surrounding normal skin. These were only epidermal, did not require suturing, and healed without scar. Deliberate elevation of the lesion above normal skin, use of lower click stops and therefore thinner slices, and gentle slicing action in the subsequent patients avoided damage to normal skin. In one patient what was thought to be a benign lesion proved to be a basal cell carcinoma. This was later treated by conventional broad excision and closure.

Summary

A simplified new method for skin grafting is based on a dermatome easily constructed from an ordinary safety razor and blades. Thickness of skin grafts' cut was measured with a micrometer of new design. The adjustable razor dermatome was found to cut grafts from .005 inch thick at the lowest setting up to .023 inch at the highest setting.

This instrument allowed precise split thickness skin grafting under local anesthesia in the office or out-patient department. One hundred patients with skin tumors, burns, varicose ulcers or traumatic defects had good to excellent results, with only one graft failure. This razor dermatome was also used to biopsy suspected skin malignancies, for definitive excision of superficial benign skin lesions, and for planing down hypertrophic scars.

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This study was supported in part by a grant-in-aid from the Gillette Safety Razor Company.

416 Marlboro Street

Books are filled with the pros and cons of the digitoxin controversy. Here is a simple clinical report on what actually happened in practice.

Digitoxin: Long Term Results

Albert Abraham, M.D./Morristown

While controversy concerning digitoxin has subsided somewhat, problems of the use and abuse of digitoxin are with us still today. I recently reviewed my experience with digitoxin therapy; results of this review are interesting. The report concerns private patients treated in my office. They were ambulatory and carried on their usual activities. A total of 109 patients were treated for cardiac insufficiency or cardiac arrhythmia, and their records were available for study. The group included 52 females. Eighty-five per cent were observed for four months or more and 60 per cent were observed for more than a year.

In patients treated for cardiac insufficiency, the efficacy of therapy was judged by relief of the symptoms of cardiac insufficiency with the smallest dose effective (with or without diuretic therapy).

Among the patients treated for arrhythmia, there were ten whose arrhythmia consisted solely of ventricular premature systoles and eighteen who had other types of paroxysmal arrhythmia including paroxysmal atrial tachycardia (the most common finding).

A little known and not widely publicized aspect of digitalis therapy is its prophylactic use for suppression of troublesome ventricular premature systoles in persons without clinical or laboratory evidence of structural heart disease. One of the causes of persistent atrial fibrillation (and of frequent paroxysmal atrial fibrillation) is hyperthyroidism. Patients with hyperthyroidism have not been included in this group.

Table I indicates the patient distribution in two separate groups: those with cardiac insufficiency and those treated prophylactically for cardiac arrhythmia. Sex distribution ratio is approximately six males to four females for cardiac insufficiency and approximately one male to four females for cardiac arrhythmia.

The duration of satisfactory therapy according to the varied dosage utilized is shown in Table II.

Table I

AGE AT START OF TREATMENT

	11–20	*21–30*	*31–40*	*41–50*	*51–60*	*61–70*	*71–80*	*81–90*	*Total*	*Total by Diagnosis*	*Total by Sex*
Cardiac Insufficiency											
Males	1	1	2	3	16	15	10	2	50		57
Females	1	1	1	3	5	12	6	2	31	81	52
Cardiac Arrhythmia											
Males	0	0	1	4	1	1	0	0	7		
Females	0	3	5	6	5	2	0	0	21	28	

Table II

DURATION OF SATISFACTORY THERAPY BY DOSAGE

	.20 Mg. Daily			*.15 Mg. Daily*			*.10 Mg. Daily*		
	Pts.	*Pts. Mos.*	*Average Mos. Satisfactory*	*Pts.*	*Pts. Mos.*	*Average Mos. Satisfactory*	*Pts.*	*Pts. Mos.*	*Average Mos. Satisfactory*
Cardiac Insufficiency	42	1652	39.	53	789	15.	8	60	7.5
Cardiac Arrhythmia	18	419	23.	12	148	12.	0	0	—

Table III discloses the most important data. The interesting data for maintenance dosage in patients with cardiac insufficiency is as follows. While it is true that for the majority of patients 0.2 milligrams was a satisfactory daily dose, almost one-third were managed more satisfactorily with 0.15 milligrams as the daily maintenance dose.

Figures for cardiac arrhythmia reveal a distribution very similar to the above in that 20 per cent of the patients were managed more satisfactorily with 0.15 milligrams daily than with 0.2 milligrams. All patients in this study received digitoxin in daily oral maintenance dosage after they were fully digitalized as judged by clinical response.

Undesirable reactions numbered six. All of these occurred in patients treated for cardiac insufficiency. On a dosage of 0.2 milligrams, three patients suffered disturbing intestinal symptoms; two patients developed A-V block. On a dosage of 0.15 milligrams, one patient developed bradycardia.

Failure of therapy was limited to two patients in the group receiving prophylactic medication. These two patients with showers of ventricular premature systoles did *not* respond to digitalis prophylaxis, although one received 0.2 milligrams daily for a period of twelve months, and the other one received 0.2 milligrams daily for a period of one month. The ventricular premature systoles in the two patients were recorded electrocardiographically. This is unusual because my experience leads me to believe that the full digitalization of a patient with bothersome ventricular premature systoles (in the absence of cardiovascular disease) usually leads to tremendous increase in comfort for the patient.

Table III

PROPORTION OF SATISFACTORY THERAPY BY DOSAGE

	Patient Months .20 mgms		*Patient Months .15 mgms*		*Patient Months .10 mgms*		*Total*
	No.	*%*	*No.*	*%*	*No.*	*%*	
Cardiac Insufficiency	1652	66.	789	31.	60	2.3	2501
Cardiac Arrhythmia	419	73.	148	27.			567

Conclusions

1. Digitoxin is a satisfactory treatment for cardiac failure.

2. Digitoxin is a satisfactory therapy for cardiac arrhythmias.

3. The dose of digitoxin necessary in a significant number of patients is 0.15 milligrams rather than 0.2 milligrams.

230 South Street

First Aid Manual In Spanish

As a means of providing health education material for your Spanish-speaking patients, the American Medical Association has translated its "First Aid Manual" into Spanish. The self-help guide provides instructions for first aid for such emergencies as shock, snake bite, insect wounds, and allergy reactions. It also contains complete instructions and diagrams for the accepted methods of artificial respiration, the treatment of hemorrhage, and many other problems of first aid.

Copies are available from "Order Handling" at 15 cents each, or less when ordered in bulk. Write to the AMA (Department of Health Education).

Can a malignant tumor metastatically embolize into a synthetic graft? It has never been reported until now. Here is what appears to be the first such case.

Tumor Embolization In A Synthetic Vascular Graft*

Joseph Alpert, M.D.
Donald K. Brief, M.D. and
Victor Parsonnet, M.D./Newark

In the voluminous literature on arterial thrombo-embolic phenomena, there has been scant reference to arterial tumor embolism.[1,2,3,4] Whether this has been due to its rarity or the difficulty and failure to demonstrate tumor in the artery is not clear. Tumor embolization in a synthetic vascular graft has not as yet appeared in the surgical record. This communication describes the occurrence of such an unique event.

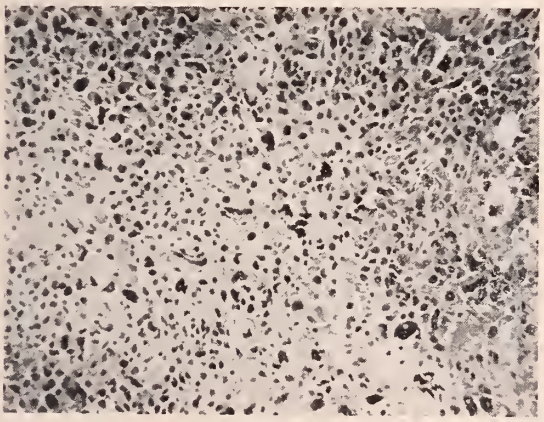


Figure 1

Primary biopsy showing extensive necrosis, cellular pleomorphism with many bizarre giant cells. Histogenesis is not apparent. (Hematoxylin and Eosin X100.)

A 49 year old non-diabetic, cigarette-smoking, bulldozer operator was hospitalized in March, 1964 with symptoms and findings characteristic of a Leriche syndrome. Translumbar aortography confirmed the presence of bilateral aorto-iliac arterial occlusion, presumably secondary to atherosclerosis. On April 7, 1964, an aorto-femoral woven dacron bifurcation bypass graft was inserted with restoration of the pedal pulses. His symptoms disappeared and he returned to work. In May, 1965, he was readmitted to the hospital because of a tender, fluctuant mass in the left buttock first noted two months previously. The aorto-femoral graft was functioning well. The lesion, at first thought to be a sterile abscess, was drained and a biopsy taken. This proved to be an undifferentiated malignant tumor (Figure 1). After radical excision, a definitive diagnosis of rhabdomyosarcoma was made. The tumor was hemorrhagic, necrotic, and appeared to be multicentric in origin (Figure 2). One week later the patient

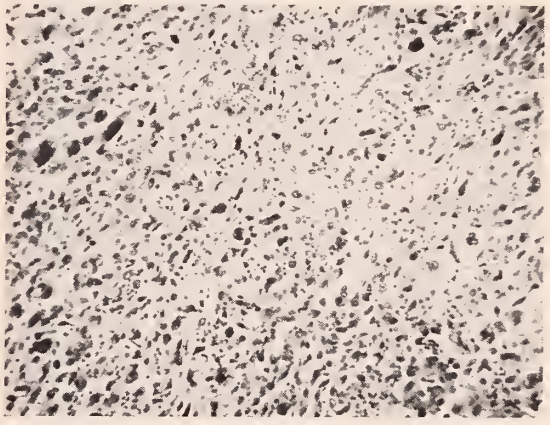


Figure 2

Section from the excised buttock mass demonstrating the undifferentiated rhabdomyosarcoma. (Hematoxylin and Eosin X100.)

complained of a sudden coolness of the left leg which then became pulseless and cyanotic. Aortography showed total occlusion of the left limb of the bifurcation graft. During surgical exploration in August, 1965, (16 months after the primary graft insertion) the left limb of the graft was found to be pulseless, and the pulse in the right limb and body of the graft was diminished. There was thrombus at the proximal anastomotic site, and retrograde thrombosis above the graft. The occluded graft was replaced with a woven dacron aorto-femoral bifurcation graft.

Examination of the occluding thrombus demonstrated the presence of neoplastic cells identical to those originally noted in the sections of the excised rhabdomyosarcoma (Figure 3). Chest x-rays did not reveal pulmonary metastases, and there was no clinical evidence of an intracardiac septal defect. The post-operative course was quite uneventful, and the patient again returned to gainful employment.

Seven months later (April, 1966), he developed intermittent claudication of the left calf and examination

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revealed decreased epicritic sensation in both feet as well as absent pedal pulses. Femoral angiography demonstrated bilateral popliteal artery occlusions with a fair distal circulation on the left, but no reconstitution on the right. The administration of intra-arterial thrombolytic agents for three days was not beneficial and a right lumbar sympathectomy was performed. Peri-aortic lymph nodes removed during this surgery were negative for metastases. Eventually, a right above-the-knee amputation was required. The occluding thrombi in the major leg vessels were microscopically free of tumor cells.

In May, 1966, he was readmitted for an infected amputation stump. Now the right femoral pulse had disappeared, although the femoral and popliteal pulses were present on the left. The amputation stump was revised on July 11, 1966. Ten days later, acute pain occurred in the left thigh and leg.

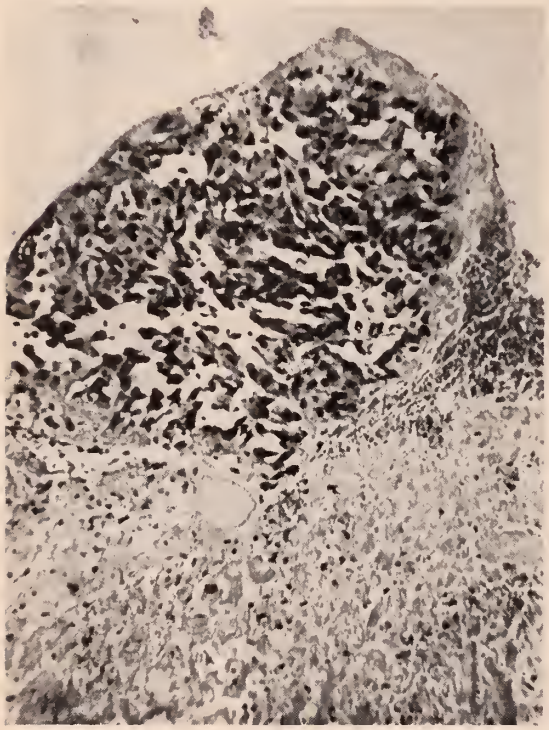


Figure 3

Graft thrombus with enmeshed pleomorphic tumor cells similar in appearance to those noted in the original tumor sections. (Hematoxylin and Eosin X100.)

The foot and leg became pale and cold with a demarcation level at mid-thigh. The left femoral artery had a slapping quality and no distal pulses were felt. At exploration, the common femoral artery and distal graft was found to be full of thrombus. A Fogarty catheter was inserted bi-directionally and copious amounts of thrombus were extracted as well as pseudo-intima from the graft. A segment of the graft was resected and replaced with an end to end 8 mm. woven dacron tube graft. The operation produced regression of the demarcation site to below the knee, but there was no restoration of a popliteal pulse. Because of progression of gangrene of the leg, an above-the-knee amputation was carried out in August. Histologic examination of the thrombus again revealed moderate numbers of atypical cells consistent with the original malignant neoplasm (Figure 4).

Postoperatively the patient experienced intermittent episodes of pulsating headaches associated with periods of mental confusion. Neurologic evaluation, including lumbar puncture and brain scan did not substantiate the suspicion of a possible brain lesion. He was eventually able to live a bed and chair existence at home where he managed quite well. His headaches, however, recurred with greater frequency, and in November, 1966 he was admitted to another hospital with further episodes of confusion, disorientation, combativeness, and intermittent generalized convulsions. He rapidly deteriorated, became comatose, and expired.



Figure 4

Thrombus surrounding tumor embolus. (Hematoxylin and Eosin X40.)

Autopsy Findings

Post mortem examination disclosed organized thrombosis of the body of the bifurcation graft, the adjacent aorta, and both renal arteries. Sections of the involved aorta demonstrated an old and completely organized thrombus, in which were enmeshed bizarre cells typical of the original rhabdomyosarcoma. At no point was there transmural invasion by tumor. Both iliac arteries were thrombosed, but no tumor cells were found in this area of thrombus. The lungs were not remarkable, although there was pulmonary edema. The branches of the pulmonary artery were patent. The pulmonary parenchyma was grossly free of tumor, but details are not available on the thoroughness of the examination. The heart revealed no septal defects; the left kidney was atrophic, weighing only 50 Grams. Examination of the brain disclosed no evidence of metastases. Death was ascribed to bilateral renal artery thrombosis.

Discussion

Malignant tumors usually spread through tissue spaces, lymph and blood vessels, body cavities, and along tissue planes.[1] Infiltrating tumors have a tendency to invade the walls of large or small veins, penetrate into the lumen and proliferate intra-luminally. Embolization to other parts of the body accounts for the development of distant metastases. Rhabdomyosarcoma, with its abundant vascularity, commonly displays early dissemination to the

lungs and generalized metastases are not usual. Invariably, pulmonary metastasis is the cause of death rather than continued local invasiveness of the tumor.[5]

The walls of arteries, on the other hand, exhibit a striking resistance to neoplastic invasion, and transmural penetration is rarely found. If malignant tumors did invade arteries, one would expect metastatic lesions throughout the peripheral distribution of the invaded vessel. Such an event would be most unusual.[1]

The left side of the heart and atheromatous ulcers of the aorta are the most common sites of origin of arterial emboli, but not of tumor emboli. Spain[6] has demonstrated in cases of arterial embolization, where there is no obvious source of the embolic material, that a thrombus in one of the pulmonary veins may be the focal cause. Similarly, Wallach[7] stated this region to be a "hitherto and frequently unsuspected site of origin" and believed that a diligent dissection of the smaller pulmonary veins would reveal the source of the systemic tumor emboli when no intra-cardiac explanation could be found. Meticulous dissections have, in fact, demonstrated that this mechanism accounts for some reported paradoxical emboli.[7] The pathogenesis of the final arterial destination is primarily pulmonary artery embolization and infarction with thrombus formation in subadjacent smaller veins, and eventual detachment of the thrombus into the systemic circulation. Spain emphasized that a careful search of the small pulmonary veins would frequently reveal additional examples of the pulmonary thrombi.

Gross observation of emboli in the systemic arterial circulation suggest that a tumor embolus is large.[1] Evidence indicates, however, that arterial tumor emboli are microscopic, and usually smaller than those reaching the lungs from the systemic veins. Most venous tumor emboli are too large to pass the pulmonary capillary bed and are, therefore, trapped in the lung. Exceptions to this mechanism have been ascribed to paradoxical embolism through intra-cardiac septal defects, retrograde venous embolism, and uninterrupted passage of tumor cells through the pulmonary capillary bed. The latter is known to occur often during tumor manipulation where, ordinarily, such free floating cells fail to grow when trapped in the systemic capillary system.[8] Tumor emboli, on the other hand consists of fragments of tumor rather than solitary cells.

In those cases of peripheral embolization in which pulmonary deposits were said to have been "absent," it is probable that a painstaking examination of the lungs was not made. According to Willis,[1] when the lungs were "apparently clear," he has consistently uncovered a malignant focus after a prolonged search.

In our patient, the tumor embolus which terminated in the graft appears to have arisen from a pulmonary venous tumor thrombus, although this remains unproven. It must be assumed that at the autopsy, the pulmonary examination was not sufficiently thorough to find a tumor focus of microscopic dimensions. (At the time of autopsy, the prosectors were unaware of the previous diagnosis of a tumor thrombus).

That free floating tumor cells can find a suitable bed in a pre-existing graft thrombus and grow in that location must be considered. However, the sudden onset of some of the episodes of embolization in which tumor was found suggests large emboli rather than isolated tumor cells. It might also be possible for malignant tumors to grow directly through the walls of a synthetic graft. This hardly seems likely as a cause of embolization in this case, since tumor was found well above the graft, and no tumor was found lying without the graft either at the original operation for replacement of the graft, or at autopsy.

Summary

The first recorded instance of malignant tumor embolization in a synthetic vascular graft is reported. An undiscovered pulmonary venous tumor thrombus is postulated as the source of the systemic arterial embolus.

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201 Lyons Avenue

Hospitals In Riot Areas

One thing learned in the summer riots is that a wounded policeman shouldn't be placed in a hospital bed next to that of a wounded rioter. Another is that a hospital's emergency supplies have to be gathered early. Once a civil disturbance gets going, there's no leaving or entering a hospital in the midst of it. During a riot, a hospital becomes a besieged fortress in which wounded, angry combatants from both sides of the fight have to be treated, guarded, and protected.

Traditional hospital "disaster plans" must be revised to accommodate the special conditions that prevail during a riot, say seven physicians on the staff of Wayne State University School of Medicine in a report to the AMA. All served at Detroit General during the 1967 outbreaks. Fourteen hundred and seventy-five patients were treated in the hospital's emergency room in six days. During the busiest 36 hours, 456 were treated. Under these conditions, only severe emergency procedures are effective, the authors point out. "Casualties resulting from a major civil disturbance occur in an atmosphere of marked emotional tension in which there is disruption of normal social mores and a disregard for the law," they said. The results have great effect on the operation of a hospital. During a riot, other parts of the hospital have to be guarded, too. It's impossible to know where violence might erupt.

One necessity is the triage officer, usually found only in military medicine. The triage officer is a physician who examines every incoming patient and determines priority of treatment, based on the seriousness of the injury and the facilities available. "In addition to broad medical knowledge, he should possess an equable temperament, sound judgment, a commanding voice, and physical stamina." Stamina becomes a problem for every member of the hospital staff. Since the length of a disturbance can't be predicted, regular rest periods must be established and enforced. Otherwise, many physicians, nurses, and others overestimate their physical reserves.

"The major difficulty in Detroit was the fact that the hospital itself was part of the hostile environment," said a *Journal* editorial. "Apathy or obstruction replaced the usual reaction of citizens on the street to the work of ambulance crews. Physicians, nurses, and hospital staff members had to risk personal injury or death to reach their homes or return to the hospital. The problem is real. It could appear again, and often.

Authors of the report were Alexander J. Walt, M.D.; Robert F. Wilson, M.D.; Irwin K. Rosenberg, M.D.; Agustin Arbulu, M.D.; Thomas J. Grifka, M.D.; Elmer F. Kobold, M.D., and Charles E. Lucas, M.D.

Diarrheal disorders in infants can be controlled with better education of all who handle children, more meticulous efforts to determine the etiology, and vigorous treatment.

Diarrheal Diseases

Joseph W. Gardam, M.D./Newark

In view of the marked increase in diarrheal diseases during the past two years — particularly in young children — an effort has been made to establish criteria helpful in arriving at a correct diagnosis and in carrying out better control through proper epidemiologic study. It seems ironic that one should run into an outbreak in which Salmonella, Shigella, and Pathogenic E. Coli infections are all present at the same time and that to the best of our knowledge, no common source or factor has been elicited. No particular area of our city, and no single social or economic class is involved. However, lower income people, living in crowded, unsanitary quarters, with many children seem to have the most cases. Poor hygienic surroundings favor the spread of this group of diseases. The more unschooled and careless the mother, the more likely we are to have multiple cases in the family. The spread is by fecal contamination of hands, (hand to mouth), and improper washing between handling sick and well children; or, secondarily, by contamination of food. Contamination of foodstuffs by roaches, mice, or rats is a possibility, but absolute proof is lacking. And so far we have been able to establish that dogs, hamsters, cats, guinea pigs, and parakeets are not factors in this outbreak. Outbreaks occur in the cool months as well as in hot weather. We find cases in adults as well as in infancy and childhood. Outbreaks traceable to one particular item are not considered in this article. This paper is primarily concerned with infants.

A formula that is too rich in fat may produce diarrhea. And we must not overlook the possibility of contamination of the formula mixtures marketed under trade names. Some of these formula products have been checked bacteriologically in our laboratories in the presence of known cases, but so far none has given us positive cultures. Our records show that Salmonella and Shigella will show up in cultures many weeks after the clinical picture has changed and the patient is supposedly well. I see no reason why a carrier state cannot exist even in young patients particularly in the group 2 of Salmonella which contains the Typhoid-Paratyphoid group and other forms of the more virulent type. Naturally with 1,100 subvarieties of Salmonella, many of these will be relatively mild and should clear spontaneously in a short period of time.

For treatment the *antibiotics* offer the only hope of shortening the course of these diseases and rooting out the carrier state. The ideal method will be to perform sensitivity tests and then use the most effective drug in a *proper dose* for the *age* of our patient, giving a full course of treatment over a 10 to 14 day period followed two weeks later with rectal swab or stool culture. Three successive negative cultures 24 hours apart must be obtained and the patient be clinically well before release of the case is possible.

All family contacts need stool cultures to eliminate unrecognized cases. Education of the family as to proper hygiene — hand cleansing after defecation (or after changing diapers), instructions as to covering foodstuffs, ordinary housecleaning in a sanitary manner, plus efforts to rid the premises of roach, mice, and rat infestation should be undertaken. Check on toilet facilities to eliminate faulty or leaking equipment.

SHIGELLOSIS

Years	1	2	3	4	5–9	10–14	15–19	20+	Age Unknown
1965	4	2	2	0	3	0	1	3	0
1966	4	6	4	2	3	1	1	3	2
1967	9	5	4	3	6	2	0	8	0
To May 1, 1968	9	2	1	3	1	0	0	0	0

SALMONELLOSIS

Years	1	2	3	4	5–9	10–14	15–19	20+	Age Unknown
1963	5	1	1	0	0	1	1	6 1 Para T	0
1964	5 1 Para T	2	1	0	2	1	0	9	0
1965	14	2	0	0	1 1 Para T	2	0 1 Typh	6 2 Typh	0
1966	14	4	2	2	7	5	8	37* 3 Para T 1 Typh	0
1967	29	3	3	3	9	5	1	9 1 Typh	1
To May 1, 1968	14	2	1	0	3	0	0	7	0

E. COLI

	Months											Years							
	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7
1966	15	5	1	0	1	1	2	1	1	1	0	0	1	7	1	0	0	0	0
1967	14	5	5	3	2	4	0	3	3	1	2	0	1	5	3	1	0	0	7
To May 1, 1968	9	2	1	3	2	1	1	1	1	1	1	0	1	1	1	0	0	0	0

To clarify the situation, a group of pediatricians were asked to express an opinion on certain phases of this situation. The first question asked was, "What age limit do you use as the end of the *newborn period?*" Two pediatricians said one month after birth; one said six weeks; and two others said they felt the newborn period was over at the end of three months. The tenth edition of *Control of Communicable Diseases in Man* says that the "newborn state was limited to those under one month of age." The time element is essential for a proper diagnosis of *Epidemic Diarrhea of the Newborn,* which is primarily limited to nurseries found in economically advanced countries (North America and Europe). The first thirty days of life will be considered the "newborn state" which is followed by the infancy period.

Following the meconium stage, normal stools are golden yellow, soft, pasty, with or without curds of undigested milk in breast fed babies, and usually 3 to 10 in number in a 24 hour period. In bottle fed infants normally somewhat fewer movements occur (3 to 7 in a 24 hour period) with some change in color and probably more curds. Thus, when diarrhea occurs, we must consider *an increase* in the number of bowel movements and *a change* in the type of stool from a soft, pasty yellow to a watery gray or rice water type, with or without mucous, and even the presence of some blood.

Infectious Diarrhea of the Newborn is usually an epidemic outbreak in a hospital nursery and is limited to the first 30 days of life—frequent rice water stools with little mucous, no blood, marked dehydration, and acidosis. Ordinarily no fever is present and laboratory cultures are negative for pathogens. Enteropathogenic Escherica Coli of 10 or more serotypes are the commonest findings. Entero Virus (ECHO or Coxachie), rarely Salmonella or Shigella, as well as others of questionable pathogenicity have been identified in various outbreaks. These children suffer a high mortality rate—20 to 40 per cent. The spread from child to child is exceedingly rapid.

*The Whitefish outbreak was in 1966.

Transmission is usually traceable to a carrier among nurses, doctors, other attendants, and mothers with infected birth canals, followed by poor personal toilet hygiene, and failure to wash hands following diaper changes and before feeding infants. Contaminated formulas, airborne (dust) transmission, contaminated bed clothing, and soiled instruments, have all been involved. Carelessness upon the part of nurses or attendants becomes a major factor for consideration in the presence of one of these explosive outbreaks. One must study the habits of *all* personnel assigned to these nurseries (including physicians) and exclude new admissions from the involved areas, discharging all patients as fast as they become well. When the last patient is moved out, thorough mechanical cleaning of the entire involved area is a necessity. This should include sterilization of *all* linens in an autoclave, scrubbing of cribs, bassinets, furniture, floors, walls, and ceilings with approved concentrated disinfectants followed by complete airing before the admission of new patients. Even repainting the entire area should be considered and done where practicable.

The Pathogenic type of E. Coli diarrhea is of real importance and should be isolated and followed up until three successive negative stool cultures are obtained. This infection occurs most frequently in early childhood diarrhea (first 6 months) and occurs by direct contact through fecal-oral transmission or contaminated food. The incubation period is short (1 to 4 days) with man as the reservoir of infection. Malnutrition is a factor in susceptibility to this disease. Control is basically one of education and training to provide good hygiene and good health practices. No quarantine nor isolation is necessary and is ordinarily not feasible; but reporting of cases to the local health authority is essential to start careful follow up and control. Obligatory reporting of diarrheal outbreaks is a real necessity. Colymycin* is probably the most effective remedy in this type of diarrhea. Here again, search for a carrier among the medical, nursing, or non-professional staff having contact with these children is a prime factor in controlling the situation. Stool cultures must be repeated. Continual education of the personnel involved (with stress on the responsibility of each person that has contact with these children) will pay dividends in preventing further outbreaks or continuance of the one in hand. Active treatment of each case is mandatory. Remember to include ward night staff in this indoctrination process.

Salmonellosis, Shigellosis, Amebiasis

In our locality we have had a marked increase in these types of diarrhea the last several years. Involvement has occurred in early childhood and throughout adult life. It has been our procedure to take stool cultures on *all* members of each family in which a case has occurred; and it is not unusual to find a second or third active case and even asymptomatic cases. In this situation, the question of carrier state becomes one for study and follow-up.

Salmonella infection is less common than Shigellas and it is often said that the infection burns itself out in a relatively short time. However, we have had many who still show positive stool cultures at the end of four months in spite of adequate treatment with chloromycetin. The ideal method of treatment would be based on sensitivity tests to determine the agent most effective in the case being treated. Three consecutive negative stools should be obtained before release of cases. Many communities permit the child to continue in school when symptom free and while the cultures are being taken. If patients are held in a hospital or at home until the usual three negatives are obtained, the hospital stay could continue over four months' time. In both Salmonella and Shigella infections man is the usual reservoir but animals can be the prime source particularly in Salmonella. The incubation period is variable but is usually one of four days. The period of communicability is during the acute illness and mainly until stools become formed. Secondary cases in families occur among preschool children. Susceptibility varies at early ages. Clinical attacks are frequently repeated and become less frequent with advancing age.

*This is the trade-name for the Warner-Chilcott brand of sodium cholistimethate.

With 1,100 varieties of Salmonella it is difficult to trace out the actual source of the infection. Bakery products (custard, cream puffs and so on), broken eggs, fish (fresh or canned), and many other items of daily foodstuffs have been infected and the organism responsible traced to them. Recently some candies sold over the counter to children have been found to be contaminated and have been recalled by the manufacturer. Some drugs (notably thyroid) have also been found contaminated with Salmonella and have been removed from the market.

Amebiasis has been relatively rare in our community and (except to recognize that it can be imported and will be found when proper stool cultures are taken) need cause us little concern.

Shigellosis is an acute bacterial disease characterized by diarrhea, fever, vomiting, cramps and tenesmus. It is world-wide in distribution and worse in overcrowded areas with poor sanitation. The fatality rate is less than one per cent, but may increase to 20 per cent in hospitalized patients. It occurs at all ages, particularly in older infants and children in the first years of life. Man is the reservoir and 27 serotypes of Shigella are recognized—divided into four main groups: Shigella Dysenteriae, Shigella Flexner, Shigella Boydii, and Shigella Sonneii. The usual spread is by fecal-oral transmission and indirectly by fecal soiled objects and food contamination. Spread by flies is not unusual. The incubation period is 1 to 7 days. Communicability persists until the infective agent is absent from feces. Susceptibility is more common in children and second attacks are frequent. Control measures require prompt reporting to the local health authority, isolation during the acute illness with rigid personal precautions by attendant, concurrent disinfection, and diligent search for mild unrecognized cases and carriers. Specific medical treatment includes fluid and electrolyte replacement and antimicrobial drugs that are shown to be specific by sensitivity tests.

Non-specific gastro-enteritis is found to produce nausea, vomiting, and diarrhea with or without fever and ordinarily *no* positive culture is found. Studies at the Childrens' Hospital in Washington, D.C. showed that about one-half of these cases were viral in origin and, in all probability, this will be the case in most areas when outbreaks occur and no satisfactory pathogen is found in stools. The limitation is due to the fact that many laboratories are not able to do viral studies with the result that stool culture reports are returned as "negative."

Many of the upper respiratory tract infections are accompanied by symptoms of gastro-enteritis and have the usual diarrhea, mild, for a day or two; or even severe enough to produce dehydration and require intravenous treatment as well as active medication. This causes worry because a correct positive diagnosis is essential in treating the disease and for preventing an outbreak of further cases. Every patient with diarrhea is a potential factor in a major outbreak of larger proportions. Each case must be studied meticulously with this in mind. As more laboratories become equipped and the personnel become trained to do viral studies, we shall make greater advances in controlling this group of diseases.

Many of the rare infections have been deliberately bypassed in this survey. This will include such agents as Pseudomonas aeruginosa, Proteus Vulgaris, Clostridium Perfringens, Group D hemolytic streptococci, members of the Klebsiella aerogenes group and staphlococci. Remember that mixed infections do occur. The need for eternal vigilance, complete follow-up, active medical treatment, and above all continual education of a population of mixed background and social status is necessary to combat this group of diseases that is only too frequent in occurrence and produces too high mortality in our newborn and infant age groups.

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This is surely the most detailed article on the anatomy and physiology of the female urethra ever published in this Journal.

The Female Urethra: Current Concepts*

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Spectacular and exciting investigative efforts during the past decade have given new perspective to that long-neglected tube whose function 25 years ago was described by Lowsley[1] as solely the conveyance of urine from the urinary bladder.

The classic descriptions refer to the female urethra as a short membranous canal, three to six centimeters long which runs obliquely downward and forward from the neck of the bladder to the external urinary meatus. It lies in the vestibule between the clitoris and vaginal orifice. Covered by the anterior vaginal wall, it perforates the two layers of the triangular ligament. The upper part of the urethra is separated from the front of the vagina by a space filled with loose connective tissue. As the urethra descends in its downward and forward course, this space becomes more indistinct, so that by the time the meatus is reached, the urethra appears to be directly in the anterior vaginal wall. In its lower half, there appears to be a fusion of the fasciae providing a single thick stratum of tissue that separates the lumen of the urethra from that of the vagina.

The pudic venous plexus borders the urethra on both sides as do the corpora cavernosa of the clitoris and the vestibular bulbs which impinge upon it laterally in its passage through the triangular ligament.

The urethral wall comprising mucous, submucous and muscular coats is elastic and readily distensible. The mucous layer consists mostly of stratified squamous epithelium and is thrown into longitudinal folds. It contains many small lacunae and mucous glands which are tubular and branching. The submucous coat is made up of loose connecting tissue and blood vessels.

The musculature is composed of an internal longitudinal layer and an external circular layer of nonstriated muscular fibers. Additional fibers, continuous with the internal sphincter of the bladder, surround the proximal end. The compressor urethral muscle, a layer of striated muscle fibers, surrounds the urethra between the layers of the triangular ligament.

The blood supply is derived from the internal pudic, the inferior vesical, and the uterine arteries. The veins drain into the perivesical or pudendal plexuses.

The lymphatics drain into the deep inguinal, external iliac, and hypogastric nodes. Innervation is from the pudic, genitofemoral and the vesical plexuses of the sympathetic.

Embryologically, the female urethra corresponds to the prostatic and membranous urethra in the male.

What new concepts have evolved during the past ten years?

Congenital Abnormalities

Congenital aberrations of an astounding variety have been described.

Absence of the urethra: This extremely rare condition is usually associated with other major anomalies, such as exstrophy of the bladder.

Duplication of the urethra: Partial or complete duplication of the urethra has been recorded, though, of course, it is uncommon.

Abnormal opening of the ureter into the urethra: This rare condition may be a cause of continual incontinence present from birth.

Anomaly of the urethra associated with persistent cloaca: Persistent cloaca is also rare and must be treated by a surgical procedure.

Hypospadias: In hypospadias — which is frequently associated with other anomalies — the urethra opens into the anterior vaginal wall. The defect may range from an opening into the vaginal wall near the external meatus to a complete absence of the urethral floor up to the level of the bladder. Incontinence is the most frequent presenting complaint, although we have seen a case in which repeated urinary tract infections were the most prominent feature.

* Read before the Sections on Obstetrics and Gynecology, and Urology, Annual Meeting of The Medical Society of New Jersey, Atlantic City, May 20, 1968.

Epispadias: More infrequent than hypospadias in the female, epispadias results from a developmental defect which, if it had been more severe, would have resulted in bladder exstrophy. Clinically, it manifests itself as a displacement of the urethra above the clitoris with a defect of the anterior urethral wall. This defect varies from a widely dilated orifice in the most mild form, to an absence of the dorsal aspect of the urethra in the second-degree form (in which case the bladder sphincter is intact and there is no incontinence) to an absence of the dorsal aspect of the urethra as well as part or all of the vesical sphincter (third degree hypospadias). The latter may be associated with abnormal development of the pubic symphysis and bladder exstrophy.

Congenital urethral strictures: Obstruction of the urethral canal may be caused by a stricture either at the external orifice or anywhere in the canal. Generally, the external meatus is involved, but fetal rests of the cloacal membrane may constitute a diaphragm or valve in the canal.

The Internal Vesical Sphincter

Experiments in male and female dogs in which the urethra was transected at various levels and placed on tension indicated that the internal sphincter is a tubular, muscular structure synonymous with the posterior urethra in the male or the entire urethra in the female, and that this portion of the urethra is actually the bladder neck. When the bladder is at rest and filling with urine, the neck or urethra maintains urinary continence by its intraluminal resistance, which depends on the inherent tension of the urethral wall, length of the urethra, and radius of the lumen.[2]

Experiments in dogs in which artificial urethras were constructed from the bladder flaps indicated that on initiation of micturition the smooth muscle of bladder fundus and neck is stimulated to contract down on the bolus of urine in the fundus. This results in a widening and shortening of the bladder neck or urethra as it tends to be pulled up into the globular fundus. In essence, the intraluminal resistance of the urethra is markedly decreased during urination, because the length of the urethra is shortened and its inside caliber markedly enlarged by active contraction of bladder and urethral musculature.

The internal vesical sphincter maintains urinary continence by virtue of the resistance it presents to the flow of urine. The urethral or internal sphincter resistance varies directly with the tension in the wall of the urethra and the length of the urethra, and inversely with the radius of the urethral lumen. The tension in the urethral wall is exerted by the inherent tonicity of the smooth muscle and elastic fibers.

When micturition occurs, the smooth muscle fibers of the bladder fundus and neck (posterior urethra) contract. This results in a widening or funneling at the vesical outlet and an apparent decrease in length of the posterior urethra. The bladder (fundus and neck) changes from a flask-shaped to a globular structure. Net result of the decrease in tension of the urethral wall, the decrease in urethral length and increase in radius of the urethral lumen, is to produce a marked decrease in urethral resistance. The changes in the posterior urethra, vesical neck or internal vesical sphincter are accomplished by active *contraction* of the smooth muscle — not relaxation.

The tension exerted by the wall of the urethra upon its luminal contents is decreased during urination because the walls of the urethra are pulled away from the lumen by longitudinal contraction of the detrusor fibers.

Clinical Applications

Theoretically, stress incontinence can occur whenever the intraluminal resistance of the urethra is decreased below a certain value. The decrease in resistance may be due to a decrease in the tension exerted by the urethral wall upon its lumen, a decrease in

urethral length, or an increase in the inside diameter of the tube.

Birth trauma, hormones, and senile changes have been proposed as factors in stress incontinence in the female. It has been suggested that these factors cause downward displacement of the bladder into the pelvis, obliteration of the posterior urethrovesical angle, loss of points of fixation for the internal sphincter, dilatation of the urethra, and funneling of the internal urethral meatus. Most of these changes are compatible with the occurrence of stress incontinence because they can all lead to a decrease in the efficiency of the internal vesical sphincter.

On the basis of these preliminary studies, a whole new avenue of consideration has evolved about factors concerning resistance in the urethra and bladder in relation to fluid flow, body positions, changes in length of the urethra and the effects of voluntary and involuntary stress. Thus, a discipline of "urokinetics" has inspired new experiments.

Urinary Hydrodynamics

Lapides[3] concludes that when intravesical pressure is low, urinary continence can be maintained solely by the primary urinary sphincter. The primary sphincter exhibits a resistance created by the tonicity of the smooth muscle and elastic tissue in its wall and by its length. Tissue tension (created by the fasciae and striated muscles immediately surrounding the urethra) contribute to the increased resistance observed in the distal two-thirds of the primary sphincter.

When intravesical pressure is elevated by straining, coughing, and stress, the effectiveness of the primary urinary sphincter must be increased to maintain continence. This is accomplished by a two-fold action of the striated pelvic and perineal muscles. The external urethral sphincter and pubococcygeus fibers of the levator ani muscles compress the primary urinary sphincter circumferentially as well as elongate it by pulling it upward or cephalad.

The primary urinary sphincter exhibits its lowest resistance to the fluid flow during micturition when urethral length is shortest and tension of the urethral wall against its lumen is least. This situation obtains not only because of relaxation of the striated pelvic and perineal muscles but because contraction of the longitudinal smooth muscle fibers of the detrusor and urethra has shortened and widened the urethra.

Hodgkinson[4] using electronic monitoring equipment, studied voluntary voiding in 184 patients by simultaneously recording intravesical pressure, intraurethral pressure, and the precise times of starting and stopping urine flow. On the basis of these studies, he felt that the following generalizations seemed reasonable:

(1) Voluntary voiding is initiated by gradually increasing and sustained pressure influences;

(2) At the instant loss of urine from the urethra, the intravesical pressure exceeds the intraurethral pressure;

(3) The crux of voluntary voiding lies in the delicate manipulation of intravesical and intraurethral pressures;

(4) Increased elevations of pressure *per se* are not directly related to successful initiation of voiding;

(5) Once voiding is freely established, both intravesical and intraurethral pressures tend to fall to lower sustained levels;

(6) With establishment of free voiding, secondary undulating waves of intravesical and intraurethral pressures become incorporated into the pressure tracings;

(7) Waves of increased intravesical and intraurethral pressure persist for as long as 45 seconds following termination of urine flow;

(8) When voiding is terminated, and when intravesical and intraurethral pressures have become stabilized, the intraurethral pressure exceeds the intravesical pressure and the intravesical/intraurethral pressure ratio of voiding is reversed.

Soferman[5] investigated urethral resistance by carbon dioxide insufflation of the urethra with continuous pressure recording. This "sphincterokymography" detailed alterations in urethral pressure during micturition consistent with other studies.

Beck[6] carried out experiments on normal women and those with stress incontinence. His results suggest that in normal continent

women, when the intraurethral pressure remains greater than the intravesical pressure at rest or with the stress of coughing, no urine is lost. In the patient with stress incontinence at rest, the pressure in the urethra is greater than the intravesical pressure, and so no urine is lost.

Very little pressure in the urethra is required to hold back 200 cubic centimeters of urine in a resting bladder. However, in the patient with stress incontinence (under the stress of coughing) the intravesical pressure become greater than the intraurethral pressure for one or more of the following three reasons:

(1) *Poor periurethral support.* Because of poor support, there is a low resting urethral pressure, and also impaired transmission of the centripetal force of increased intra-abdominal pressure to the lax urethral wall.

(2) *High intra-abdominal pressure effect.* Action upon the bladder and urethra. The "high pressure effect" is caused by the bladder neck and upper urethra slipping back from the symphysis pubis into the line of maximal downward intra-abdominal pressure thrust as described by Hodgkinson.

(3) *Scar tissue effect.* In these cases, there is impaired transmission of the centripetal force of increased intra-abdominal pressure with cough to the urethra. There is also impaired action of the periurethral musculature because the periurethral scar tissue has converted the urethra into a rigid drainpipe.

In a consideration of the hydrodynamics of micturition in normal females, Karl-Axel Backman[7] lay stress on the necessity of calculating the diameter of the urethra during micturition from recorded intravesical pressure and urinary flow rate. The method employed involves the use of the Law of Bernoulli which gives the hydrodynamic relation of pressure, flow rate, and diameter of a tube at turbulence.

The best way of expressing the *space* of the urethra must be by means of the diameter.

Simultaneously, radiographs of the bladder and urethra were taken using a roll-film changer giving a maximum of eight exposures per second. This makes it possible to add information of the actual intravesical pressure and flow rate to every radiograph. The hydrodynamic diameter calculated from those flow rates and pressures can, therefore, be checked by means of the urethral diameter measured on the film.

Shopfner[8] performed voiding cystourethrography in children to evaluate the roentgen features of distal urethral obstruction. A comparison of urethrographic diameters with urethral calibration, forced and intermittent urination, vesicoureteral reflux, bladder trabeculation, and documented urinary tract inflection failed to reveal any pathologic correlation between them.

Meatal and distal urethral narrowing, urethral dilatation, and splaying of the urinary stream are not valid roentgen criteria of meatal and distal urethral stenosis.

Shelley and Warrell[9] have devised an intraurethral wire gauge to overcome deficiencies in intraurethral balloons.

In their study, intravesical pressure was recorded by a small transducer, intra-abdominal pressure changes were monitored by a radiopill in the rectum and the forces closing the urethra by the urethral force gauge. All these results are recorded simultaneously on a multi-channel ultra-violet recorder. This arrangement of apparatus gives direct recordings and can be used with the patient in any position and during movement.

They concluded that in women with normal urinary control and in women with moderate stress incontinence, the increase in intra-abdominal pressure caused by change in posture from supine to sitting is transmitted to the urethra. In women with moderate stress incontinence, a cough with the patient supine usually causes a positive impulse; yet a similar cough in the sitting position usually opens the proximal urethra.

It would thus appear that sitting up reduces the competence of the urethral sphincter mechanism and this fits the fact that most women with stress incontinence suffer this symptom when sitting or erect but not when lying flat.

Enhornung[10] suggests that stress incontinence occurs because the intra-abdominal pressure increases produced by coughing are not completely transmitted to the urethra. This is an important new concept but it is difficult to prove because the urethral closure forces cannot be measured by an intraurethral balloon when the urethra is dilated. An alternative explanation is that in women with stress incontinence the anatomy of the sphincter mechanism has been damaged in such a way that an increase in intra-abdominal pressure is transmitted more efficiently as a urethral dilating force than as a urethral closure force. The diminution in urinary control seen on sitting may have a similar explanation.

Kleeman[11] devised a simple but accurate method of measurement of urethral resistance employing a special equation. This clearly determines the degree of obstruction to the flow of urine from the bladder to the outside.

Using different uroflometers, Pierce,[12] Stewart,[13] and Paquin[14] have recorded urethral resistance in a variety of circumstances to an accurate degree. Paquin[14] has established on these bases a series of so-called urethral profiles in which resistances and urethral radii are calculated by the Bernoulli principle.

Ardran[15] and his associates introduced evidence based on similar anatomic experiments on dog bladders which, they assert, disputes Lapides' concept of the fundamental importance of urethral length in incontinence. They conclude that there is a primary urinary sphincter functional at the bladder neck or that part of the urethra which crosses the bladder wall from the internal meatus to the external surface of the bladder. Zinner[28] and Davis[29] concur on this.

A mathematical model of the urethra has been created by Stibitz.[27] He hypothesized that models having the form of surfaces of revolution may be used to represent the urethra under pre-voiding pressure. From such models are derived formulas for calculating the muscle tension from the shape of a urethrogram.

Stress Incontinence

On the basis of these fundamental preliminary studies, Lapides,[3] Leadbetter[16] and others have defined the lesion of stress incontinence. They say that when intravesical pressure is markedly elevated by exertion, urethral resistance must be increased to prevent incontinence. In the normal female, this is accomplished by a two-fold action of the striated muscle of the urogenital diaphragm and pelvic floor. These muscles compress the urethra or urinary sphincter circumferentially as well as elongate it by pulling it cephalad toward the fundus. Net result of the striped muscle activity is to decrease the caliber of the urethral lumen, to increase the tension of the urethral walls against its lumen, and to increase the length of the urethra — all factors which increase the resistance of the urinary sphincter to the flow of fluid through it.

The basic abnormality common to females with stress incontinence was found to be an unusually short urethra when the patient assumed the standing position. There is shortening, telescoping, or collapse of the urethra. The former emphasis on urethrovesical angulation is now relegated to insignificance and the philosophy of correction is directed at lengthening the urethra and appending it in such fashion that foreshortening will not prevail in the erect position. Adhering to this concept, then, it follows that operations designed to buttress the posterior aspect of the urethra are erroneous and should be confined to correction of cystocele, urethrocele, and uterovaginal decensus!

Like Marshall and Marchetti,[17] Lapides[3] uses anterior urethropexy. Other operations utilized for stress incontinence have been efficacious only when they have resulted inadvertently in an improvement in the factors affecting the efficiency of the internal vesical sphincter.

Tsuji[18] devised a method of urethral reconstruction with a pedicle bladder tube. Harper and Russell[19] have shown that urethrovesical lysis affects urethral resistance and improves

urinary incontinence because of postoperative elongation of the urethra.

The most imaginative and inspiring surgical correction has been that introduced by Leadbetter.[20] His unique method of lengthening the urethra with a full thickness bladder wall tube and reimplanting the ureters superiorly in the bladder has evoked enthusiastic reception and employment. Evaluation five years after introduction of his method has led Leadbetter[20] to believe that sphincteric action is produced by trigonal muscle from which the new bladder neck is formed.

The Base Plate

In a fascinating and continuing group of studies, Hutch[21,22,23,24,25] has evolved a new theory of the anatomy of the internal urinary sphincter. The crux of these experiments is the existence of a structure in the floor of the bladder completely surrounding the internal urethral orifice. It is flat and "platelike" at all times except during voiding when it is converted into a cone-shaped object. By use of lateral cystograms, cineradiography, and detailed studies of the microscopic anatomy of the bladder neck, Hutch[25] defined the structure. The urethral orifice is located slightly anterior to its center. The posterior part of the "base plate" consists of the trigone; the anterior and lateral parts are made up of a condensation of smooth muscle rings emanating from the middle circular layer of the vesical wall, arranged concentrically around the internal urethral orifice.

These rings of smooth muscle, the fundus ring, close the bladder neck when the base plate is flat. For voiding to begin, the "base plate" must be forced out of its flat position into an early cone position. After this has occurred, continued contraction of the muscles in the fundus ring completes the process of funnel formation and voiding ensues.

Hutch[24] postulates that the "base plate" *is* the internal sphincter. He describes two other urinary sphincters. The urethral sphincter (smooth muscle) in the upper two to three centimeters of the urethra consists of circularly oriented smooth muscle which originates as the outer longitudinal layer of the bladder. The external sphincter (striated muscle) is divided into two parts: the sphincter compressae urethrae — the striated sphincter lying between the two layers of the urogenital diaphragm — and the para-urethral striated muscle.

Shopfner[26] studied bladder neck and urethral pathology with sequential cystourethrography with particular emphasis on the late stages of voiding. He describes a new-roentgen anatomic structure, the trigonal canal which develops and exists only during the act of voiding. This is created near the end of voiding by the shortening of contracting muscle fibers of the bladder base plate which progressively tug and elevate the opposing walls of the base plate to a vertical position. The base plate anatomically is made up of the trigone and fundus ring. It is flat in the mature, filled, and resting bladder. For voiding to commence, the base plate must be forced out of its normal flat position into the cone formation. Once this has happened, continued contraction of the muscles in the fundu ring carries the process of funnel formation to completion, and voiding takes place. The activity observed in the roentgenograms consists of a structure that starts out in a silver-dollar shape, is converted into a funnel, and finally into a tube which is the trigonal canal.

Comment

Comparison of the presently understood mechanism of micturition with older concepts of this mechanism reflects the enrichment by data from radiology and biophysics. The individuality of each phase of the voiding act has been stressed by recent investigations. It is necessary that all the hydrodynamic factors be considered, not just flow, resistance, or pressure alone. To translate biophysical terms to physiologic terms, one must take account of all the structures involved in filling and emptying of the urethra, muscle, nerve, pelvic floor, and nervous ramifications. The hydrodynamic analysis of urethral flows of

governing diameters and the neurologic interrelations between the urethra and bladder further supplement concepts of the anatomical vesicourethral interrelations.

Three major views of flow initiation are current. Lapides[2] proposes that the bladder neck is pulled open by active contraction of the detrusor, fibers of which sweep past the bladder neck into the urethra in such a manner as to expand the neck upon contraction. Another opinion proposes that the bladder is innervated reciprocally, and the initiation of micturition may be due to relaxation of urethral musculature. A third concept is suggested by Hutch[22] who believes that the bladder neck is surrounded by a form base plate. Before urination begins, the central portion of the plate is depressed and this causes it to form a funnel configuration which releases tension on the vesical neck and allows voiding to occur.

As the voiding act begins, the detrusor contracts and bladder pressure rises steeply. The bladder base descends, the pelvic floor relaxes, the urethra shortens and the bladder neck opens. Urine fills the proximal urethra and the sphincter opens, also involuntarily. Flow begins. At the termination, the external sphincter area closes first, followed by reversal of the voiding process. The role of abdominal force to initiate or complete micturition is auxiliary although there is a tendency to fix the diaphragm and strain during urination. The period of latency between the decision to void and initiation of flow is inversely related to bladder volume. If urination is upon need, latency is short; if upon volition, it is longer. Flow rates tend to vary directly with volume. Volitional interruption of the stream occurs at the external sphincter during a one to two-second period. The urethra is compressed and elongated by this muscular contraction.

Summary

Factors relating to the structural and functional properties of the female urethra conducive to incontinence are reviewed. Congenital aberrations, the influences of stress and trauma, and the effect of disease are evaluated. Aspects of anatomy and physiology relating to surgical approach are considered.

A citation list of 29 references appears in Dr. Pinck's reprints.

124 Gregory Avenue

Meningitis Films Available

Ayerst Laboratories, distributors for Beecham Research Laboratories, has now made available the new medical film — *Bacterial Meningitis.* The film, in color and sound (running time — 25 minutes), is narrated by Paul H. Wehrle, M.D., Professor of Pediatrics, University of Southern California. Dr. Wehrle discusses concepts in the differential diagnosis and treatment of bacterial meningitis, as well as complications associated with the disease. Methods of treatment, including drug therapy, are considered. The disease is presented from the viewpoint of the problems faced by the practicing physician. This film can serve as the platform for a provocative program on the diagnostic and therapeutic aspects of bacterial meningitis.

In addition to *Bacterial Meningitis,* two other films on infectious disease are presently available from Ayerst Laboratories: *Chronic Bronchitis — A Team Affair* (color, sound, running time — 30 minutes) and *Reprieve from Lethal Infection* (color, sound, 18 min.)

To receive any or all of these films, write to Beecham Research Laboratories, c/o Ayerst, 685 Third Avenue, New York City 10017.

NEW JERSEY DOCTORS' NOTEBOOK

Trustees' Minutes

November 17, 1968

A regular meeting of the Board of Trustees was held on November 17, 1968 at the Executive Offices in Trenton. Detailed minutes are on file with the secretary of your county medical society. A summary of the significant actions follows:

New Jersey Rehabilitation Commission — Golden Jubilee Symposium . . . Took the following actions, which resulted from a conference of representatives of the New Jersey State Rehabilitation Commission and The Medical Society of New Jersey (called at the request of the Medical Director of the Commission, Jarvis M. Smith, M.D.) concerning the celebration of the fiftieth anniversary of the founding of the Commission (April 10, 1919):

1. That MSNJ officially cosponsor the Golden Jubilee Symposium of the New Jersey Rehabilitation Commission.

2. That addressograph runs connected with the Symposium be made at no expense to the Commission.

3. That Joseph A. Lepree, M.D. (Chairman of the MSNJ's Committee on Occupational Health, Workmen's Compensation, and Rehabilitation) serve as the official representative of MSNJ to work with the planning committee for the Golden Jubilee Symposium.

The celebration will take the form of a symposium from 1 to 5 p.m. at the Brunswick Inn, New Brunswick, on April 16, 1969, to be followed by a reception and dinner.

Therapeutic Abortion . . . Agreed to endorse the following protective provisions, requested by the Essex County Medical Society, and to submit them to the Abortion Law Study Commission for consideration:

1. No person shall be required to perform or participate in medical procedures which result in the termination of pregnancy; and the refusal of any person to perform or participate in these medical procedures shall not be a basis for civil liability to any person nor a basis for any disciplinary or other recriminatory action against him.

2. No hospital, hospital director or governing board shall be required to permit the termination of human pregnancies within its institution. Refusal to permit such procedures shall not be grounds for civil liability to any person nor a basis for any disciplinary or other action against it by the State or any person.

Legislative Consultant . . . Approved the report of the Executive Director announcing the appointment of Mr. Edward F. Meara, III, as Legislative Consultant to The Medical Society of New Jersey, effective November 1, 1968. Mr. Meara has agreed to the following:

1. To be present at each session of the New Jersey Legislature and to follow closely the progress of legislation identified as of particular concern to the Society;

2. To maintain close contact with the two members of MSNJ officially designated as the legislative educational representatives of the Society to advise and guide them in discussions with the leaders and key members of the Legislature concerning bills of special importance, and to keep them informed concerning the status of such measures and the means best suited for attaining the Society's objectives with reference to them;

3. To work under the direction of and in close cooperation with the Executive Director, acting for the Council on Legislation, to whom the Legislative Consultant will make periodic reports as indicated.

Daytop Village Presentation — 1969 Annual Meeting . . . Approved (at the request of the Chief of the Bureau of Narcotic Addiction and Drug Abuse of the New Jersey State Department of Institutions and Agencies) presentation at MSNJ's 1969 Annual Meeting of a play, whose entire cast is composed of ex-addicts, entitled, *Concept,* produced by Daytop Village, Inc., a narcotic rehabilitation facility in New York. The presentation will be financed by the Department of Institutions and Agencies, and is tentatively scheduled for 9 o'clock on the evening of May 17, 1969 in the Viking Room of Haddon Hall.

Physical Therapy Examining Board — Amendments to S-722 . . . Concurred in the decision of the Executive Committee in approving amendments to S-722 which evolved during a

conference with representatives of the New Jersey Chapter of the American Physical Therapy Association, the New Jersey Society of Physical Medicine and Rehabilitation, the New Jersey Hospital Association, and The Medical Society of New Jersey:

1. The inclusion of the sentence, as a preface to the definition of physical therapy, which reads: "Physical Therapy or Physiotheraphy shall be administered only on specific referral or direction of a licensed physician."

2. That the physician-member of the proposed Physical Therapy Examining Board will be "a Board Certified Physiatrist nominated by The Medical Society of New Jersey."

Blood Donor Programs . . . Received the report of Dr. Eckstein that under the auspices of the State Department of Health an *ad hoc* committee has been formed to act statewide in strengthening the present blood donor programs and thus belay encroachment in this area by the Greater New York Blood Program.

Blue Cross-Blue Shield 65 Contract . . . Received and noted a communication from Dr. Joseph P. Donnelly (President of Blue Shield) pointing out that a rider to pay for laboratory and x-ray services in physicians' offices will be available in 1969.

Communicable Diseases In New Jersey

The following communicable diseases were reported to the Division of Preventable Diseases during November:

	November 1968	*November 1967*
Aseptic Meningitis	19	10
Primary Encephalitis	2	1
Post-Infectious Encephalitis	0	0
Hepatitis, Total	248	115
Infectious	210	83
Serum	38	38
Malaria	9	14
Servicemen	4	13
Civilian	5	1
Meningococcal Meningitis	8	8
Mumps	228	546
German Measles	25	25
Measles	35	51
Salmonella	36	56
Shigella	12	12

Influenza

In mid-November, influenza of the A2 Hong Kong 68 type was confirmed among residents of State institutions at New Lisbon, and Bordentown in Burlington County and among individuals in the Trenton area. An influenza-like illness has also been reported from Camden and Middlesex counties. Laboratory results are pending from these areas. The illness has been very mild, characterized by fatigue, headache, low grade fever, some upper respiratory congestion and a sore throat. There have also been consistent complaints of muscle aches especially around the shoulders. Due to the mildness of these symptoms, most of these cases will not be brought to the attention of physicians.

The current polyvalent and bivalent influenza vaccines do not appear to confer protection against the new A2 Hong Kong Strain. The new influenza vaccine was expected to be available in New Jersey by mid-December. It was anticipated that it would first be given to the elderly and chronically ill.

The Acute Communicable Disease Program (Telephone: 609-292-5590) would appreciate learning about any groups such as schools, colleges, institutions, factories and the like where influenza-like illness is occurring.

Gonorrhea Control

Perhaps, a better title would be "Gonorrhea Out of Control." The trend of reported cases in New Jersey has been rising steadily since 1965. There can be little doubt that the incidence of gonorrhea is increasing (see graph). Although the true incidence of gonorrhea in New Jersey is unknown, it is conservatively estimated that *50,000* new cases occur each year.



Major obstacles to the control of gonorrhea are:

1. *Incomplete reporting by private physicians.* In 1965 a physician-attitude survey was conducted which indicated that only 3.7 per cent of the gonorrhea cases treated by private physicians were reported to the health department. When cases are not reported to the health department, infected contacts continue to be major vectors for the spread of gonorrhea.

2. *The short incubation period in males.* In males 85 per cent of the infections produce clinical symptoms within six days thus allowing the disease to be spread rapidly. Typically signs and symptoms of male patients are sudden onset of frequent, painful urination accompanied by a profuse, mucopurulent, urethral discharge.

3. *The asymptomatic nature of gonorrhea in females.* A significant obstacle to the control of gonorrhea is the inability to diagnose most infected females or to determine their recovery following treatment. Complications of gonorrhea in the female, (particularly acute and chronic pelvic inflammatory disease) are well recognized, but clinically the female presents few signs and frequently is totally asymptomatic. This carrier state provides the reservoir which serves to perpetuate this infection within the population. Only 25 per cent of the females infected with gonorrhea will have a positive Gram stained smear. Thus, it is worth emphasizing that this diagnostic method is unreliable in the recognition of gonorrhea in the female and should not be used for this purpose.

4. *The lack of any natural or acquired resistance to this disease.*

5. *The decreasing sensitivity of the organism to penicillin.* Each year, nationally, we see an increase in the number of gonococcal strains displaying a decreasing sensitivity to the action of penicillin.

6. *The lack of an adequate serologic test for gonorrhea.* In the past few years, gonorrhea diagnostic research has produced improvements in FA technics, a selective medium for the growth of *N. gonorrhea,* and strides toward an effective seriologic test. However, laboratory diagnostic methods are applicable only to those who present themselves for diagnosis; therefore, an adequate screening test for gonorrhea must be developed if we are to find the asymptomatic carriers.

Even in the face of these obstacles, a substantial measure of control can be obtained with current recommended therapy, recently developed diagnostic procedures, and increased case finding activities.

Recent Library Acquisitions—Winter 1968

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Fees In Workmen's Compensation Cases

The Council on Medical Services has reviewed complaints of physicians that their fees for services to State employees are being arbitrarily reduced. In this connection, the Board of Trustees has approved the following position statement:

Workmen's Compensation Fees For Physicians' Services Rendered To State Employees

The Council on Medical Services has through the years received complaints from physician-members concerning a fee schedule used by the State of New Jersey for medical services rendered to its employees in compensation cases. The Council has been authorized by the Board of Trustees to prepare a statement in explanation of the extant situation. That statement is as follows:

"Section 34:15-15 of the New Jersey Workmen's Compensation Act provides that the employer shall 'furnish to the injured workman such medical, surgical, and other treatment, and hospital service as shall be necessary.' When the employer fails or neglects to do so the employee may secure such treatment and services as may be necessary, and the employer shall be liable to pay therefor. "In instances where the employer has failed to contract with and provide treating physicians, the following is applicable; 'All fees and other charges for such physicians' and surgeons' treatment and hospital treatment shall be reasonable and based upon the usual fees and charges which prevail in the same community for similar physicians', surgeons', and hospital services.'

"The State of New Jersey has not entered into contractual agreements with providers of services for compensation treatment to its employees. It chooses to permit its employees to have the free choice of physician. Since State employees work at many and divergent geographic locales, New Jersey has by administrative decision established a fee schedule for physicians treating State employees in compensation cases. The State maintains that such a method is the only efficient means of administering its program.

"It is incumbent therefore that all members of The Medical Society of New Jersey be aware of the fact that the State of New Jersey in order to allow its employees the free choice of physician will compensate all treating physicians according to an established fee schedule and will not pay the usual and customary fee. The physician who will not settle for less than his usual and customary fee should not treat a State employee for a compensation related injury or illness or should in the alternative prior to instituting treatment, inform the patient that he will hold him personally accountable for the difference between the State fee schedule and his usual and customary charges."

Report Reactions To Air Pollution

When you see that air pollution has had a deleterious effect on a patient, report this promptly to our Committee on Air Pollution, c/o The Medical Society of New Jersey, Post Office Box 904, Trenton, New Jersey 08605.

MEETINGS OF MEDICAL INTEREST

This listing has been compiled by the Academy of Medicine of New Jersey. For additional information, including exact time of meetings, write to the society or hospital listed.

1969
January

7 **Hudson County Medical Society**
"Cancer In Situ"

8 **Gloucester County Tuberculosis and Health Association**

8 **Middlesex County Medical Society**

8 **Ocean County Medical Society**

8 **Mercer County Medical Society**
State Hospital
Trenton

8 **The Academy of Medicine of New Jersey, American Academy of General Practice, and Middlesex General Hospital**
Middlesex General Hospital
New Brunswick
"Rationale for Modern Treatment of Diabetes"

8 **The Academy of Medicine of New Jersey**
Englewood Hospital
Englewood
"Management of the Menopause"

9 **Essex County Medical Society**
Hotel Suburban
East Orange
"National Medical Association Potentials"

14 **Bergen County Medical Society**

15 **Bergen Pines County Hospital**
Division of Internal Medicine
Paramus
"New Aspects of Cor Pulmonale"

15 **The Academy of Medicine of New Jersey, American Academy of General Practice, and Middlesex General Hospital**
Middlesex General Hospital
New Brunswick
"Mechanisms of Salt and Water Retention and of Diuresis"

16 **Gloucester County Medical Society**

16 **Morris County Medical Society**

16 **Essex and Morris County Medical Societies with Sandoz Pharmaceuticals**
Sandoz Auditorium
Hanover
"Medicare and Medicaid in Family Practice"

21 **The Academy of Medicine of New Jersey**
Section on Dentistry
Fairleigh Dickinson School of Dentistry
Teaneck
"Anthropology in Growth and Development in Relation to Dentistry"

22 **The Academy of Medicine of New Jersey, American Academy of General Practice and Middlesex General Hospital**
Middlesex General Hospital
New Brunswick
"Coronary Heart Disease"

22 **The Academy of Medicine of New Jersey**
Overlook Hospital
Summit
Symposium: "Coronary Care"

22 **Bergen Pines County Hospital**
Division of Internal Medicine
Paramus
"Recent Advances in Diabetes Mellitus"

22 and 23 **Muhlenberg Hospital**
Plainfield
"Infectious Diseases"

27 **Cape May County Medical Society**

28 **Hunterdon County Medical Society**

29 **The Academy of Medicine of New Jersey**
Section on Pediatrics
Morristown Memorial Hospital
"Neuroblastomas"

29 **The Academy of Medicine of New Jersey, American Academy of General Practice and Middlesex General Hospital**
Middlesex General Hospital
New Brunswick
"Polyurias"

29 **Ocean, Burlington, and Monmouth County Heart Associations**
Ocean County College
Toms River
"Current Concepts in Coronary Care"

February

4 **Hudson County Medical Society**
"Recent Advances In Cancer Therapy"

5 and 12 **Muhlenberg Hospital**
Plainfield
"Infectious Diseases"

11 **Bergen County Medical Society**

11 **Cumberland County Medical Society**

12 **Mercer County Medical Society**
State Hospital
Trenton

12 **Essex County Heart Association**
St. Barnabas Medical Center
Livingston

12 **Gloucester County Tuberculosis and Health Association**

12 **Middlesex County Medical Society**

12 **Ocean County Medical Society**

14-15 **American College of Surgeons**
New Jersey Chapter
Trip to Cleveland Clinic
Cleveland, Ohio

18 **Warren County Medical Society**

19 **The Academy of Medicine of New Jersey and American Cancer Society, New Jersey Division**
Symposium: "What's New in Cancer"

19 **Essex and Morris County Medical Societies with Sandoz Pharmaceuticals**
Sandoz Auditorium
Hanover
"Treatment of Ski Injuries"

19 and 26 **Muhlenberg Hospital**
Plainfield
"Infectious Diseases"

20 **Gloucester County Medical Society**

20 **Morris County Medical Society**

26 **Bergen Pines County Hospital**
Division of Internal Medicine
Paramus
"Recent Advances in Cancer Chemotherapy"

26 **New Jersey Gastroenterological Society Newark**

26 to Mar. 1 **New Jersey Academy of General Practice**
Sheraton-Deauville Hotel
Atlantic City
Convention

March

4 **Hudson County Medical Society**
"Modern Concepts About Immunization"

5 and 12 **Muhlenberg Hospital**
Plainfield
"Infectious Diseases"

7-9 **The Academy of Medicine of New Jersey and Bergen Pines County Hospital**
Marriott Motor Inn
Saddle River
"Current Concepts in Respiratory Disease"

11 **Bergen County Medical Society**

12 **Gloucester County Tuberculosis and Health Association**

12 **Mercer County Medical Society**
State Hospital
Trenton

12 **Middlesex County Medical Society**

12 **Ocean County Medical Society**

12 **Bergen Pines County Hospital**
Division of Internal Medicine
Paramus
"Gout and Uric Acid Metabolism"

19 **The Academy of Medicine of New Jersey**
Symposium: "Management of Gastrointestinal Hemorrhage"

19 **Bergen Pines County Hospital**
Division of Internal Medicine
Paramus
"Acute Leukemia"

19 and 26 **Muhlenberg Hospital**
Plainfield
"Infectious Diseases"

20 **Gloucester County Medical Society**

20 **Morris County Medical Society**

20 **Essex and Morris County Medical Societies with Sandoz Pharmaceuticals**
Sandoz Auditorium
Hanover
"Rheumatic Fever: Diagnosis and Treatment"

25 **Hunterdon County Medical Society**

26 **Bergen Pines County Hospital**
Division of Internal Medicine
Paramus
"Diuretic Agents and Therapy"

31 **Cape May County Medical Society**

April
1 **Hudson County Medical Society**
"Changes In Medical Care and Practice"

2 **The Academy of Medicine of New Jersey**
Section on Obstetrics and Gynecology
Symposium: "Gynecological Neoplasms"

2 **Bergen Pines County Hospital**
Division of Internal Medicine
Paramus
"Chronic IPT — Pathogenesis and Management"

2 and 9 **Muhlenberg Hospital**
Plainfield
"Infectious Diseases"

8 **Bergen County Medical Society**

8 **Cumberland County Medical Society**

9 **Gloucester County Tuberculosis and Health Association**

9 **Mercer County Medical Society**
State Hospital
Trenton

9 **Middlesex County Medical Society**

9 **Ocean County Medical Society**

15 **Warren County Medical Society**

16 **Essex and Morris County Medical Societies with Sandoz Pharmaceuticals**
Sandoz Auditorium
Hanover
"Treatment and Management of Puberty, Pimples, and Adolescence"

16 **The Academy of Medicine of New Jersey**
Pediatric Symposium

16 **The Academy of Medicine of New Jersey**
Section on Dentistry
VA Hospital, East Orange
Symposium: "The Dentist's Role In Facial Pain And Its Management"

16 and 23 **Muhlenberg Hospital**
Plainfield
"Infectious Diseases"

17 **Gloucester County Medical Society**

17 **Morris County Medical Society**

23 **Bergen Pines County Hospital**
Division of Internal Medicine
Paramus
"Porphyrin Metabolism"

26 **Kessler Institute of Rehabilitation**
Mayfair Farms
West Orange
20th Anniversary Dinner

May
6 **Hudson County Medical Society**
Election of Officers

7 **Bergen Pines County Hospital**
Division of Internal Medicine
Paramus
"Present Day Treatment of Chronic Renal Disease"

13 **Bergen County Medical Society**

14 **Gloucester County Tuberculosis and Health Association**

14 **Mercer County Medical Society**
State Hospital
Trenton

14 **Ocean County Medical Society**

15 **Gloucester County Medical Society**

15 **Morris County Medical Society**

17-21 **MSNJ Annual Meeting**
Haddon Hall
Atlantic City

18 **The Academy of Medicine of New Jersey**
Symposium: "The Diagnosis of Life and Death"

20 **Warren County Medical Society**

21 **Bergen Pines County Hospital**
Division of Internal Medicine
Paramus
"Adrenalcortical Insufficiency"

22 **Essex and Morris County Medical Societies with Sandoz Pharmaceuticals**
Sandoz Auditorium
Hanover
"Genetic Factors Affecting Drug Response"

26 **Cape May County Medical Society**

27 **Hunterdon County Medical Society**

28 **Middlesex County Medical Society**

Treatment of Anal Ulcer and Hemorrhoids

On March 5, 1969, a program will be offered on the surgical treatment of anal ulcer and hemorrhoids. The guest speaker is James A. Ferguson, M.D., Chief of Colon and Rectal Surgery at the Ferguson Clinic, Grand Rapids, Michigan. The meeting is sponsored by the Pennsylvania Society of Colon and Rectal Surgery, and will be held at the Union League, Broad and Sansom Streets, Philadelphia. There is a reception at 6:30 p.m., followed by dinner at 7:30 p.m. You may make reservations by mailing a check for $12.50 to Valentine R. Manning, Jr., M.D., 3336 Aldine Street, Philadelphia.

Calling All Ophthalmologists

This is an invitation to participate, on a one-day voluntary basis, in the New Jersey College of Medicine's eye mobile unit for year-round screening. This project has the backing of our Society, by action of the Board of Trustees (April 21, 1968—p. 264, June 1968 JOURNAL), and of the Academy of Ophthalmology, but there has been difficulty in getting sufficient numbers of ophthalmolgists to staff the unit.

Please contact Dr. Alfonse A. Cinotti at the New Jersey College of Medicine, 24 Baldwin Avenue, Jersey City, if you have time to give.

OBITUARIES

Dr. Francis A. Barone

A former Lieutenant Colonel in the Army, Francis A. Barone, M.D., died on November 10, 1968. Dr. Barone, who was born in 1902, was a graduate of the medical school of Georgetown University, class of 1928. He was a general practitioner with special interest and experience in the field of industrial medicine and surgery. He was associated with the Fairmount Hospital in Jersey City, and for many years served as senior physician to the Jersey City Board of Education. Dr. Barone retired from active practice in 1967.

Dr. Harry Bloch

With the death on November 6, 1968, of Harry Bloch, M.D., Union County lost one of its best known internists and cardiologists. A Bellevue graduate, class of 1920, Dr. Bloch entered private practice in Elizabeth, New Jersey, soon after completing his internship. He did graduate work in cardiology and internal medicine and served all three hospitals in Elizabeth, eventually becoming chief of internal medicine or attending cardiologist at these institutions. An emeritus member of the Union County Medical Society, he was 74 years old at the time of his death.

Dr. Michael J. Bonomo

Dr. Michael J. Bonomo, a well-known Northern New Jersey surgeon died on September 10, 1968. In his professional career, Dr. Bonomo was associated with four major hospitals in the Newark area — Presbyterian, Columbus, Clara Maass, and Newark City Hospital. Dr. Bonomo was 79 at the time of his death. He had received his medical degree at Bellevue in 1921 and was a Fellow of the American College of Surgeons.

Dr. Richard F. Buckley

Word has just been received of the death on August 13, 1968, of Richard F. Buckley, M.D., a Hoboken plastic surgeon. Dr. Buckley was born in 1911 and received his medical degree at Georgetown in 1933. He served in the medical corps of the Army of the United States during World War II, attaining the rank of major. He was an active member of of our Hudson County Medical Society.

Dr. John J. Burne

At the grand age of 84, Dr. John J. Burne, a pioneer general practitioner in Essex County, died on November 8, 1968. He received his M.D. from the University of Maryland in 1910 and was a 1960 laureate of the Golden Merit Award of The Medical Society of New Jersey. For many decades, Dr. Burne was active in committee work with the Essex County Medical Society. He was born on the day that Grover Cleveland (another prominent New Jersey native) was elected President of the United States.

Dr. Philip D'Ambola

At the untimely age of 46, Philip R. D'Ambola died, after a brief illness, on November 5, 1968. He was a family doctor in the Newark area and was active in the affairs of the our Essex County Medical Society. Dr. D'Ambola was born in 1922 and was on the staffs of Columbus, Clara Maass, and St. Michael's Hospitals. He was also a member of the American Academy of General practice.

Dr. William L. Deignan

Essex County lost one of its active and busy members on October 16, 1968, with the death that day of William L. Deignan. Born in 1900, Dr. Deignan received his M.D. at the University of Vermont in 1928. He was a general practitioner in East Orange with a special interest in surgery. Dr. Deignan maintained a busy hospital practice, affiliated with the Orange Hospital Center, with St. Vincent's in Montclair, and St. Mary's Hospital, also in Orange.

Dr. Samuel W. Ebenfeld

Dr. Samuel W. Ebenfeld, an East Orange surgeon, who was President of our Essex County Medical Society in 1960, died on Columbus Day, 1968. Born in 1898, Dr. Ebenfeld received his M.D. degree from the Albany Medical College in 1923. After internship at St. Michael's Hospital in Newark, he elected to set up practice in that city, and was associated with St. Michael's over the years in various staff positions. He was President of the Essex Couny Inter-Professional Health Council in 1961, and the previous year held the same position with the Essex County Blood Bank.

Dr. Abe S. Finkelstein

One of the state's leading pediatricians, Abe Finkelstein, died on October 12, 1968. Dr. Finkelstein earned his M.D. at George Washington University in 1927. He was an early diplomate in pediatrics, and was chief of pediatrics at the Newark Beth Israel Hospital at the time of his death. He was a senior attending pediatrician at the Babies Division of the United Hospitals of Newark. During World War II, he was a major in the medical corps of the Army of the United States. Dr. Finkelstein was 64 at the time of his death.

Dr. Frank J. Goff

At the age of 79, Frank J. Goff, M.D. died at his home in Red Bank on August 28, 1968. Dr. Goff was in the medical school class of 1922 at Bellevue and became a prominent Monmouth County surgeon. He was associated with the Riverside Hospital in his home town. During World War II, Dr. Goff attained the rank of Lieutenant Colonel in our Army's Medical Corps. He was a member of the Monmouth County Medical Society.

Dr. S. Bernard Kaplan

A pioneer in gastroenterology in Essex County, Dr. Samuel Bernard Kaplan died on November 7, 1968 at the age of 79. In 1923 he was graduated from the medical school of Emory University in Atlanta, Georgia. Completing his internship at the Beth Israel Hospital in Newark, he went into practice in that city. He was one of the earliest practitioners in the county to specialize in gastroenterology, and was one of the founder-members of the American College of Gastroenterology. He was active in committee work with the Essex County Medical Society.

Dr. T. Lloyd Kolbay

On November 25, 1968, Middlesex County lost one of its best known family doctors with the death on that day of T. Lloyd Kolbay, M.D. Dr. Kolbay was affiliated with the Kennedy and St. Peter's Hospitals, and for several years had been assistant medical director of the Roosevelt Hospital. He was born in Czechoslovakia in 1918 and received his M.D. at the University of Prague in 1942. He was in the Army of the United States from 1948 to 1952, being demobilized as a major in the medical corps. He came to Metuchen in 1950 and had been serving the people of that area until his death.

Dr. Benno Liegner

Dr. Benno Liegner, who was born in 1889, died in 1968 on September 30. He was a well known Essex County obstetrician and gynecologist and was a Fellow of the College of Obstetrics and Gynecology. He received his M.D. at the Breslau University in Germany in 1914. He was on the staff of the East Orange General Hospital.

Dr. Raymond Potter

Word has just been received from Deerfield, Florida, of the death in that city of Raymond Potter, M.D. Dr. Potter was a 1967 recipient of our Society's Golden Merit Award. He was born in 1891 and died on August 11, 1968. Dr. Potter was an active member of the Essex County Medical Society until his retirement to Florida in 1964. He was a gynecologic surgeon — a Fellow of the American College of Surgeons. He had received his doctorate degree in 1917 at the College of Physicians and Surgeons, Columbia University.

Dr. Nathan H. Ram

Caldwell mourned the loss of Nathan H. Ram, M.D., one of the leading practitioners of that borough and hailed there as the model of the family doctor. Dr. Ram was born in 1906 and died on September 30, 1968. He began his professional career as a registered pharmacist, obtaining his Ph.D. in 1931, and the following year he entered medical school in Cincinnati. He was awarded his M.D. in 1936 and identified himself with Caldwell borough after completing his internship. Dr. Ram was a captain in the medical corps of the Army of the United States from 1942 to 1946. He was on the staff of the Montclair Community Hospital.

Dr. Ernest Robinson

Dr. Ernest Augustus Robinson was one of the senior members of our Monmouth County Medical Society. He received his M.D. degree at Howard in 1915 and devoted his professional life to general and family practice. Dr. Robinson was interested in the work of the Salvation Army and served for many years as their medical adviser. When the Asbury Park Housing Authority was established he was named as one of its first members. He died on November 8, 1968, at the grand age of 81.

Dr. William H. Seward

The director of radiology at the Orange Hospital Center, Dr. William H. Seward, died on November 11, 1968. He was a member of the Essex County Medical Society and was an early Fellow of the American College of Radiology. Dr. Seward was a board diplomate in his chosen field. He was a 1929 graduate of the medical school of the University of Pennsylvania, and was 64 years old at the time of his death.

Dr. Theophilus Siemion

At Hialeah, Florida, on August 15, 1968. Theophilus R. Siemion died after a long illness. He had, for years, been a prominent medical and surgical figure in the Delaware Valley. He was a surgeon who had obtained his M.D. degree in 1923 at Hahnemann and practiced in Trenton. He was active in the Mercer County Medical Society. In 1917, Dr. Siemion, then only 21, was commissioned a captain in the medical administrative corps and served for several years thereafter in the medical corps itself. He was associated with the surgical service of all three Trenton hospitals.

Dr. Russell B. Stone

The founder of the Phillipsburg Emergency Squad, Dr. Russell B. Stone, died on November 4, 1968 at the age of 76. A 1920 alumnus of the medical school of the University of Pennsylvania, Dr. Stone was a long-time member of our Warren County Medical Society, and served the Warren Hospital in all ranks from clinical assistant, eventually becoming chief of staff of the hospital. For 33 years, he was principal plant physician at Ingersoll-Rand.

Dr. Edward B. Tyson

One of the best known cardiologists in southern New Jersey, Edward B. Tyson, M.D., died on October 9, 1968. Dr. Tyson, who was born in 1913, received his medical degree in 1941 at the medical school of the University of Pennsylvania. He became active in the affairs of our Cape May County Medical Society, and was awarded fellowship in the American College of Cardiology and in the American College of Chest Physicians. He was chief of cardiology at the Mercy and at the Shore Memorial Hospitals. He was also a Fellow of The American College of Physicians.

Dr. Samuel E. Weiner

At the age of 82, Dr. Samuel E. Weiner, a retired Atlantic City general practitioner, died on April 8, 1968. He had received his M.D. at the Medical Chirurgical College of Philadelphia in 1908. Dr. Weiner was active in the affairs our Atlantic County Component Medical Society. He entered the Army of the United States immediately after our entry into World War I in 1917 and served throughout that conflict, first as a lieutenant and then as a captain.

BOOK REVIEWS

The Knife is not Enough. Henry H. Kessler, M.D. New York, 1968, Norton. Pp. 295. Illustrations 23. ($5.95)

Only a handful of New Jersey physicians have really won international renown. There was, of course, Harrison Martland; and a number of New York and Philadelphia medical greats have lived in New Jersey. Perhaps this paucity of international fame for our New Jersey profession was due to the fact that we went so long without a medical school. Whatever, the reason, this honor roll is disappointingly small. But one of the luminaries in it is Henry Kessler. Errands of rehabilitation have taken him to the four corners of the earth. He has long been obsessed with the single idea: that the physically handicapped *can* be rehabilitated. And from the early 1920s until today, Henry Kessler has been a dynamic force in the world of physical rehabilitation.

He has worked in the Philippines and in Jugoslavia, in Australia and Austria, in China and in Greece. You name it. He's been there. But we like to think that whether he's in Samarkand, San Juan, or Siberia, he still had a tie that binds him to New Jersey. And why not? Here he was born, here he was reared, here began the nation's first modern rehabilitation clinic, and here is his beloved Institute, named for him, the concrete realization of his long, long dream.

This aptly titled book is his biography. It is warm, human, readable, accurate, and interesting. Surgeons often take things away from people — whether diseased appendices or malignant growths. But here is how a surgeon put things back into people — not only things, but functions. And with that he gave them hope, too.

The book is salted with anecdotes which will interest all readers, but which have a special application to New Jersey physicians — particularly the launching, through Dr. Kessler, of many orthopedic and rehabilitative ideas including cineplastic surgery, from its experimental beginnings with the Italian surgeons, through the work of the extraordinary Dr. Ferdinand Sauerbach, to the full flowering of cineplastic surgery as developed by Henry Kessler.

Many of us have ideas, plans, hopes, and aspirations. Henry Kessler had all these, too. But he translated them into action. How did he do all that? Here's how.

HENRY A. DAVIDSON, M.D.

Maintenance Therapy for the Geriatric Patient. Jacob L. Rudd, M.D.; Reuben J. Margolin, Ed. D. Springfield, Illinois, 1967, Charles C. Thomas Publishers. Pp. 295. ($9.75)

Maintenance therapy is defined by the editors here as the therapeutic measures which will retard deterioration in patients who are chronically ill by slowing or arresting the process, albeit temporarily. It is regarded as a fifth phase of medicine along with prevention, diagnosis, treatment, and rehabilitation.

The text is suitable for supporting medical personnel such as social workers, nurses, and nursing home administrators. While the subjects covered relate to the chronic conditions encountered in the geriatric population such as diabetes mellitus and arthritis, the general level of discourse is such that it offers little in the way of new information to physicians.

With an ever increasing number of geriatric patients to be cared for, this text should be of interest to those who assist the physician with this important segment of patient care.

EDWIN KELLERMAN, M.D.

Ethical Issues in Medicine. Edited by E. F. Torrey, M.D. Boston, 1968, Little Brown. (Price not stated) Pp. 432

Technical decisions are easier than moral ones. Whether to treat a peptic ulcer surgically or medically can be worked out by applying a reasonably objective formula. But many issues today have to be decided on moral or ethical grounds, and most of us haven't given much thought to this. Shall we tell the Board of Education that the driver of the school bus is an alcoholic or a homosexual? Or do we respect the patient's privacy? You won't find the answer is any *materia medica*. What shall we tell the dying patient? What do we do about providing contraceptive information to a wife with genetic defects? What are the ethics of artificial insemination, or euthanasia, or organ transplants? And, in this modern world, one must even ask whether physicians have the right to strike.

Here is an anthology that asks many hard questions. It doesn't give many easy answers. But it certainly starts the little grey cells working. Some of the chapters — the one on privacy, for instance, or on truth telling — are highly practical indeed. Others are more speculative. But all are thought provoking.

This is not a "must" book to help you practice your profession. But it is a unique volume in providing a rich personal experience in reading, in thinking, and in self communion. I know of no other book quite like it.

VICTOR HUBERMAN, M.D.

Lee Harvey Oswald and the American Dream. Paul Sites, Ph.D. New York, 1968, Pageant Press. Pp. 261. ($4)

This detailed biography of Lee Harvey Oswald suggests, as others have, that Oswald was frustrated, insecure, and alienated from other people. Now *if* Oswald had, in fact, killed the President (and Dr. Sites nowhere assumed that he had), he did so to fulfill a need to be recognized instead of rejected. Dr. Sites, as a sociologist, sees Oswald as a man frustrated by failure to achieve the American dream. Thus, Dr. Sites offers us a sociological rather than a psychological explanation. The style of the book is a bit pedestrian. The text opens with a 30-page essay on the radical right and the radical left, which is slow reading, salted with stereotypes like "poverty begets poverty" or "preferential treatment on the basis of race must never be allowed to become public policy." As the volume has neither a table of contents nor an index, it is hard to wend your way through the text. The Lee Harvey Oswald story is dramatic enough to justify an in-depth analysis, and to that extent this book is a genuine contribution to the topic.

ABRAHAM LEFF, M.D.

Spare-Part Surgery: The Surgical Practice of the Future. Donald Longmore. New York, 1968, Doubleday. Pp. 192. Illustrated. ($5.95)

The book contains an abundance of exciting material. It requires an occasional self administered pinch to recall that the adventuresome story of tissue and organ replacement, the subject of *Spare-Part Surgery* is highly relevant now, and not a futuristic science fiction fantasy.

A fine explanation of the immune reaction (so often recently referred to both in the scientific and lay press during the recent plethora of cardiac transplants) is offered in the book, as well as a good readable description of extracorporeal machines which is very helpful for those not actively working in the field.

Dr. Longmore suggests that as our knowledge of genetics and tissue growth technics enlarges, perhaps the future will include grown as well as made spare parts. He proposes and defines very well a World Tissue Service making replacement reserves available internationally. Perhaps world harmony will come first at a cell and organ level, before that of emotion and body.

The book is attractively bound and well printed. It is profusely illustrated and contains many plates in color. It is part of the Doubleday Science Series, which reports on man's knowledge in several scientific and technical fields.

I would suggest this book for those active in replacement and plastic surgery. It is a good general reference work on the subject of organ transplant knowledge for hospital libraries, and certainly is of interest to any active mind concerned with the progressive march of modern medicine.

The subtitle of the book, *The Surgical Practice of the Future* seems unwise for it appears that such extensive surgical activity requires much more in terms of preoperative and postoperative care than can be offered to the patients of the usual surgical practitioner. Thus, witness already the region of development of specialized renal and cardiac surgical centers as suggested in the DeBakey Report.

As procedures become more complex and further specialized, certainly spare part surgical replacement will not be the domain of the usual surgical practice. I feel certain that the author, who is presently a consultant engaged in surgical research at the National Heart Hospital, is aware of this and was surprised at his acquiescence to the subtitle, *The Surgical Practice of the Future.* ROBERT K. SPIRO, M.D.

How to Live with Hypoglycemia. Charles Weller, M.D. and Brian Richard Boylan. New York, 1968, Doubleday. Pp 130. Illustrated. ($4.50)

The collaboration of a well qualified internist and a science writer gives a book which is remarkable for its completeness but marred by poorly worded statements. The ostensible object of debunking the hypoglycemia faddist is accomplished by the complete enumeration of the causes of hypoglycemia and conditions simulating it. It reminds us that, although the causes of hypoglycemia may be obscure, there are many clear cut, curable reasons for it. The book cites illustrative cases showing the various causes of the hypoglycemic syndrome. This is occasionally a little long winded in the description, but it makes very interesting reading.

The authors offer an unusual sprinkling of inaccurate statements, unfortunately, possibly detectable only by the more specialized reader, but still detracting from the factual nature of the book. On the subject of narcoleptic-like symptoms accompanied by hypoglycemia, the authors state that a low carbohydrate, high protein diet was effective in eliminating the entire picture. Then comes the statement, "Once cured, most cases of narcolepsy do not recur, although there have been exceptions to this rule." In the chapter on hypoglycemia in children, they write: "Most of these infants (born of diabetic and prediabetic mothers) are born with a greatly enlarged pancreas which creates a state of hyperinsulinism." The latter statement does not stand up under the scrutiny of the pathologist. Again — "There are no known drugs that can elevate blood sugar." The authors had forgotten diazoxide used for treatment of metastatic insulinomas, that are inoperable. Overlooking these occasional questionable statements, the book is a good review for the lay reader on the subject of hypoglycemia.

EVERETT O. BAUMAN, M.D.

Infection Control in the Hospital, Chicago, 1968, American Hospital Association. Pp. 140 ($3.75—paperback)

Here is a manual containing much useful information for the hospital worker who needs a handy desk reference. The text covers the epidemiology of infection, general organization of responsibility, specific responsibilities of individuals and hospital departments, methods of prevention and control of infection, and special problems in that area.

It is concise and authoritative and provides a good bibliography. The charts, sample forms, and diagrams are excellent. Of special value is the chapter dealing with the "infection control committee" — its functions, its composition, the importance of the hospital epidemiologist and infections control nurse, and the methods of monitoring infections and infective situations. This book is highly recommended to hospital personnel at all professional levels.

DOMINIC A. MAURIELLO, M.D.

Science and Psychoanalysis: Animal, Human. Edited by Jules H. Masserman, M.D. New York, 1968, Grune and Stratton. Pp. 277. Illustrated. ($12.75)

In 1967, the annual meeting of the Academy of Psychoanalysis was devoted to animal and human aspects of the biologic, psychiatric, and neurologic aspects of behavior. In all, eighteen papers were presented and are here offered in book form. There is little continuity between the separate essays, which is, perhaps understandable. They range from notes on the socialization of wolves to problems of mother-son copulation among monkeys (which is a rare phenomenon). Much of the animal study has been based on the observations of primates. There is discussion of fixed motor pattern in ethologic theory, of disturbances on the mother-infant role in animals as well as in humans, of the basic psychology and neurology of the sucking reflex, and of the "neuronal model hypothesis of imprinting." Inevitably, the material varies from one essay to another, and it is difficult to get any consistent line through the entire symposium. While not an example of "must" reading, the text is an interesting and, in many chapters a thought provoking work on a topic that has very little attention in the world literature. WILLIAM SCHRAM, M.D.



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Warnings—Watch for the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism, retinal thrombosis); if present or suspected discontinue the drug immediately.

British studies reported in April 1968[1,2] estimate there is a seven- to tenfold increase in mortality and morbidity due to thromboembolic diseases in women taking oral contraceptives. In these controlled retrospective studies, involving 36 reported deaths and 58 hospitalizations due to "idiopathic" thromboembolism, statistical evaluation indicated that the differences observed between users and non-users were highly significant. The conclusions reached in the studies are summarized in the table below:

Comparison of Mortality and Hospitalization Rates Due to Thromboembolic Disease in Users and Non-Users of Oral Contraceptives in Britain.

Category	Mortality Rates		Hospitalization Rates (Morbidity)
	Age 20-34	Age 35-44	Age 20-44
Users of Oral Contraceptives	1.5/100,000	3.9/100,000	47/100,000
Non-Users	0.2/100,000	0.5/100,000	5/100,000

No comparable studies are yet available in the United States. The British data, especially as they indicate the magnitude of the increased risk to the individual patient, cannot be applied directly to women in other countries in which the incidences of spontaneously occurring thromboembolic disease may differ.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or sudden onset of proptosis, diplopia or migraine. Withdraw medication if papilledema or retinal vascular lesions are found.

Since the safety of Ovulen in pregnancy has not been demonstrated, it is recommended that pregnancy be ruled out for any patient who has missed two consecutive periods before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the first missed period.

A small fraction of the hormone agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

Precautions—Pretreatment physical examination should include special reference to the breasts and pelvic organs, and a Papanicolaou smear.

Endocrine and possibly liver function tests may be affected by Ovulen. Therefore, it is recommended that such tests if abnormal be repeated after the drug has been withdrawn for two months.

Pre-existing uterine fibromyomas may increase in size under the influence of progestogen-estrogen preparations.

Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation.

In breakthrough bleeding, and all irregular vaginal bleeding, consider nonfunctional causes. Adequate diagnostic measures are indicated in undiagnosed vaginal bleeding.

Carefully observe patients with a history of psychic depression and discontinue the drug if severe depression recurs.

Any possible influence of prolonged Ovulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study.

A decrease in glucose tolerance has occurred in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be observed carefully while receiving Ovulen.

Because of the effects of estrogens on epiphyseal closure Ovulen should be used judiciously in young patients in whom bone growth is not complete.

The age of the patient constitutes no absolute limiting factor, although Ovulen therapy may mask the onset of the climacteric.

The pathologist should be informed of Ovulen therapy when relevant specimens are submitted.

Adverse Reactions—A statistically significant association has been shown between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: cerebrovascular accidents, neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement, secretion), change in weight, changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, allergic rash, rise in blood pressure in susceptible individuals, mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme and nodosum, hemorrhagic eruption, itching.

The following laboratory results may be altered by oral contraceptives: hepatic function: increased sulfobromophthalein and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T^3 uptake values; metyrapone test; pregnanediol determination.

References: 1. Inman, W. H. W., and Vessey, M. P.: Brit. Med. J. 2:193-199 (April 27) 1968. 2. Vessey, M. P., and Doll, R.: Brit. Med. J. 2:199-205 (April 27) 1968.

Before prescribing see Detailed Product Information.

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"Sexual impotence treatment with methyl testosterone – thyroid (ANDROID) a double blind study" – Montesano, Evangelista: Clinical Medicine, April 1966.

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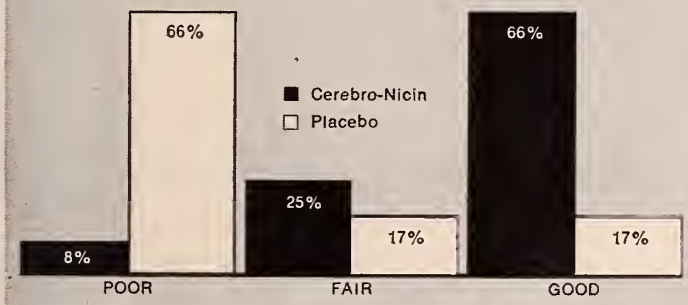
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*A Double-Blind Study of Cerebro-Nicin, Therapy for the Geriatric Patient, R. Goldberg Jrnl,. of the Amer. Ger. Soc. June, 1964

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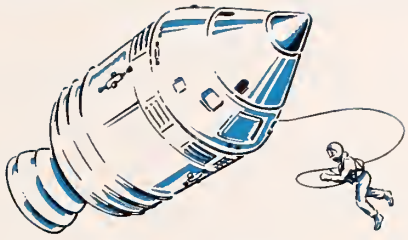
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Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

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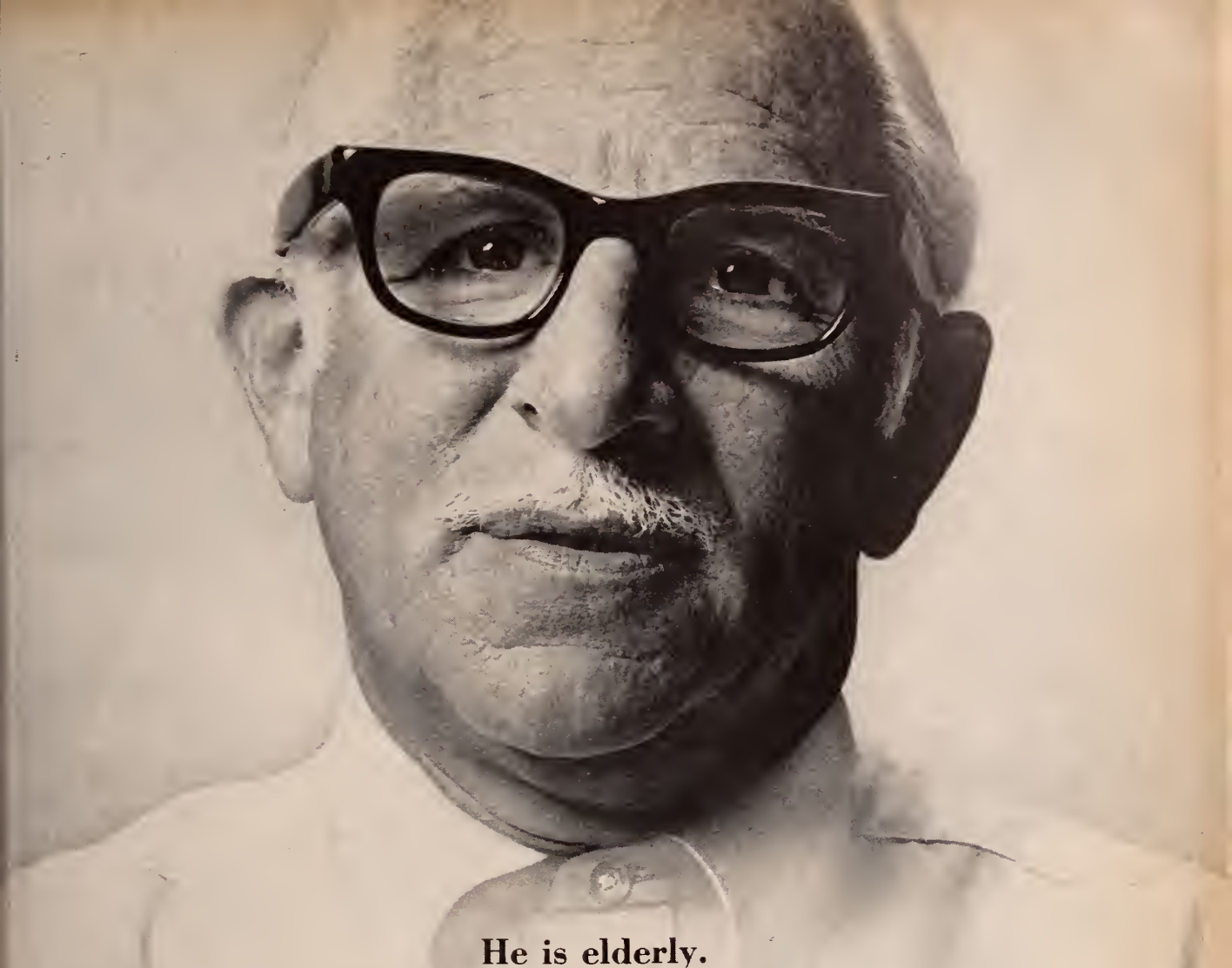
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Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

Lederle

LEDERLE LABORATORIES
A Division of American Cyanamid Company, Pearl River, New York

345-8

The AMBAR SCRAPBOOK of Obesity Oddities

FACT & LEGEND



CONTROL FOOD AND MOOD ALL DAY LONG WITH A SINGLE MORNING DOSE

AMBAR #2 EXTENTABS®

methamphetamine HCl 15 mg.,
phenobarbital 64.8 mg. (1 gr.)
(Warning: may be habit forming).

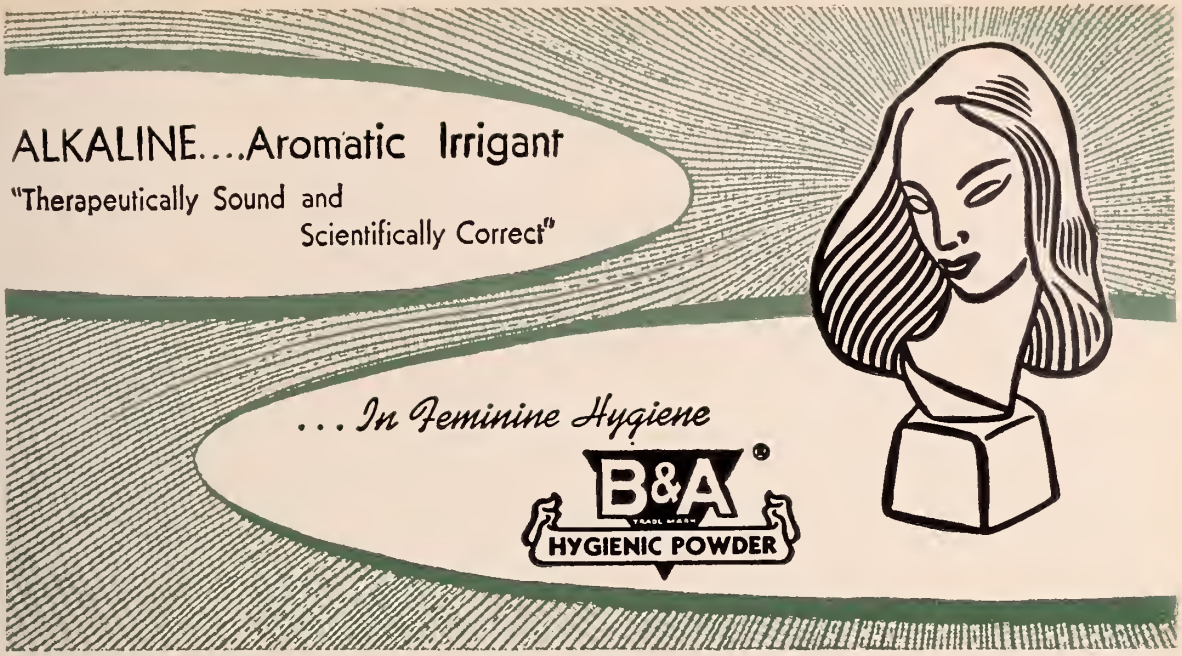
One Ambar Extentab before breakfast can help control most patients' appetite for up to 12 hours. Methamphetamine, the appetite suppressant, gently elevates mood and helps overcome dieting frustrations. Phenobarbital, the sedative in Ambar, controls irritability and anxiety...helps maintain a state of mental calm and equanimity. Both work together to ease the tensions that erode the willpower during periods of dieting.

Also available: Ambar #1 Extentabs®—methamphetamine hydrochloride 10 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

BRIEF SUMMARY/**Indications:** Ambar suppresses appetite and helps offset emotional reactions to dieting. **Contraindications:** Hypersensitivity to barbiturates or sympathomimetics; patients with advanced renal or hepatic disease. **Precautions:** Administer with caution in the presence of cardiovascular disease or hypertension. **Side Effects:** Nervousness or excitement occasionally noted, but usually infrequent at recommended dosages. Slight drowsiness has been reported rarely. See package insert for further details.

A. H. ROBINS COMPANY,
RICHMOND, VA. 23220

A·H·ROBINS



"Early in 1953 Davis and Grand undertook a review of well established practices connected with the treatment of T. vaginalis infections. For instance, it had been accepted that an acid douche should be employed. This was based on cultural studies showing that when the pH was below 5 the organisms would die. They found that the commonly used vinegar douche with a pH of 3 showed no visible effect on T. vaginalis under the microscope in 15 minutes. Both citric and lactic acid were tested with similar results. Davis then recalled that in his early treatment of T. Vaginalis infections over 30 years ago he had had his first successes with alkaline preparations, and when he returned to their use the patients reported them more soothing than the previously used acid solutions."

(Am. J. Obst. & Gynec., 68:559, 1954)

Criteria for Cleansing Douche

"Daily douching often is a part of the treatment administered in dealing with T. vaginalis and since it is possible that the solution might contain agents that could hamper the regrowth of Doederlein bacillus, the following properties were said to be ideal.

1. It should contain a harmless, nonsensitizing detergent to remove mucous deposits and debris.
2. It should not contain any antibacterial agents, since the contact possible during douching would be so fleeting that anti-bacterial action could not be expected.
3. It should be acid in pH.

The 3rd property seems to be the most illogical and unimportant. If contact is so fleeting that antibacterial actions could not be expected, it would seem to follow that its acid quality would be of no consequence. Furthermore, acid solutions are irritating to the mucosa and oftentimes accentuate inflammation.

Actually, the value of a douche is generally conceded to be confined to its use as a cleansing and deodorizing agent. The encouraging results achieved with a detergent douche solution in treating infections of the vagina are probably attributable to the enormous normal recuperative powers of the vaginal tissues which have been under-estimated as a factor in the restoration of normal physiology.

Therefore, simple cleansing of the vagina with a non-irritating, mildly alkaline douche which is soothing to the vaginal mucosa and which penetrates and flushes out the dead organisms, debris and mucinous materials frequently enables the physiological processes to overcome the infection."

Charles B. Marek, M.D., Chief of Gynecology; Bon Secours Hospital: personal communications August 11, 1964

For physician samples write to:

ERL

Eastern Research Laboratories, Inc. • 302 S. Central Ave. • Baltimore, Md. 21202

no gag





DIA-QUEL actually tastes good

DIA-quel contains the only therapeutically active ingredient of paregoric—tincture of opium. This has been combined with homatropine methylbromide and pectin to make a sensible antidiarrheal formula.

By leaving out paregoric's outdated preservative—bitter-tasting camphor—we've produced an antidiarrheal that is good-tasting, as well as effective and prompt-acting in acute, nonspecific diarrheas and their accompanying "cramps." It is DIA-quel, a clear, red liquid with a pleasant cherry flavor.

Each teaspoonful (5 ml.) of DIA-quel Liquid contains:
Tincture of Opium... 0.03 ml.—Equivalent to 0.75 ml. of paregoric.
(Warning: May be habit forming)
To reduce hypermotility and frequency.
Homatropine Methylbromide... 0.15 mg.
A safe dose for mild spasmolysis to curb cramping and griping.
Pectin... 24. mg.
Demulcent, adsorbent. Helps form stools.
Alcohol 10% by volume.

In case you're curious, back in the 1700's paregoric was being used for diarrhea, but since the state of the pharmaceutical art was extremely primitive, fungus growth in the medication was a problem. Bitter-tasting camphor was added to prevent such growth and anise oil was added in an attempt to cover up the camphor taste. DIA-quel Liquid is a modern formulation that does not contain either of these outdated ingredients.

Caution: With use of DIA-quel Liquid observe the usual precautions associated with opium derivatives and anticholinergics.

Dosage: Usual adult dosage: 1 or 2 tablespoonfuls (15 or 30 ml.) t.i.d. or q.i.d. Usual children's dosage (Clark's rule): ½ to 2 teaspoonfuls (2.5 to 10 ml.) t.i.d. or q.i.d.

How Supplied: In 4 fl. oz. (118 ml.) band-sealed bottles.

DQJ20968

DIA-quel is a Federally exempt narcotic (Class X) preparation. Where state law permits, no prescription is necessary.

For a complimentary sample of DIA-quel, simply mail your request to us on a signed prescription blank.

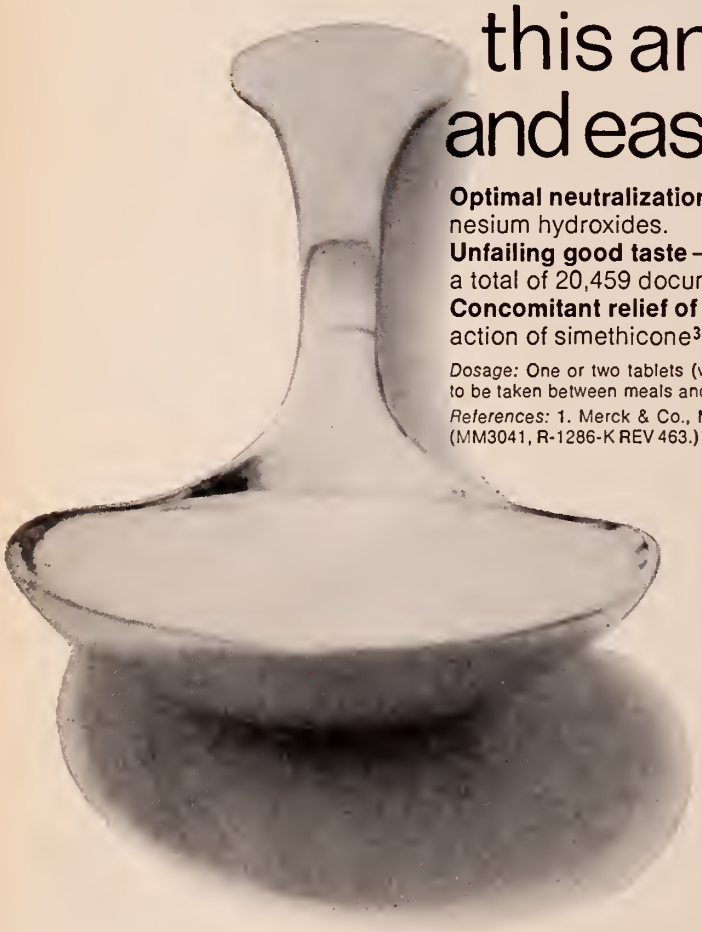
DIA-QUEL LIQUID

IPC
REG. U.S. PAT. OFF.

INTERNATIONAL PHARMACEUTICAL CORP.
Warrington, Pennsylvania 18976

the thousandth teaspoonful

Peptic ulcer patients find the thousandth dose of this antacid as effective and easy-to-take as the first!



Optimal neutralization[1] — provided by the combination of aluminum and magnesium hydroxides.

Unfailing good taste — confirmed by 87.5% of 104 patients in one study, after a total of 20,459 documented days on Mylanta Liquid or tablets.[2]

Concomitant relief of G. I. gas distress — provided by the proven antiflatulent action of simethicone[3].

Dosage: One or two tablets (well chewed or allowed to dissolve in the mouth); one or two teaspoonsful to be taken between meals and at bedtime, or as directed by physician.

References: 1. Merck & Co., Merck Chemical Division: Antacid Literature Survey, Rahway, New Jersey. (MM3041, R-1286-K REV 463.) 2. Danhof, I.E., report on file. 3. Hoon, J.R.: Arch. Surg. *93*:467 (Sept.) 1966.

Mylanta®
LIQUID/TABLETS
aluminum and magnesium hydroxides *plus* simethicone

Stuart Division/ATLAS CHEMICAL INDUSTRIES, INC./Pasadena, Calif. 91109

See next page for prescribing informati



You've made it one of your specifics in acute otitis media

DECLOMYCIN®
DEMETHYLCHLORTETRACYCLINE



You've made it one of your specifi in acute otitis medi

DECLOMYCIN acts against many strains of H. influenzae, pneumococci and streptococci, most common invaders. In otitis media, where is difficult to isolate the causative organism, tl coverage may be important. However, some str may be resistant and other pathogens can be involved.

You've found the high serum levels of DECLOMYCIN important, too. Its prolonged ac permits convenient 300 mg b.i.d. or 150 mg q.i.d. administration.

When specimens are obtainable, your culture studies will indicate the usefulness of DECLOMYCIN.

Effectiveness: DECLOMYCIN Demethylchlortetracycline should be equally or more effective therapeutically than other tetracyclines in infections caused by organisms sensitive to the tetracyclines.

Contraindication: History of hypersensitivity to demethylchlortetracycline.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, entero pruritus ani. Skin—maculopapular and erythematous rashes; case of exfoliative dermatitis has been reported. Photosens onycholysis and discoloration of the nails (rare). Kidney—rise ir apparently dose-related. Transient increase in urinary output, times accompanied by thirst (rare). Hypersensitivity reactions caria, angioneurotic edema, anaphylaxis. Teeth—dental stainir low-brown) in children of mothers given this drug during the latt of pregnancy, and in children given the drug during the neonat od, infancy and early childhood. Enamel hypoplasia has been s a few children. If adverse reaction or idiosyncrasy occurs, disco medication and institute appropriate therapy. Demethylchlo cycline may form a stable calcium complex in any bone-forming with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. S be given 1 hour before or 2 hours after meals, since absorp impaired by the concomitant administration of high calcium c drugs, foods and some dairy products. Treatment of strepto infections should continue for 10 days, even though symptom subsided.

DECLOMYCIN®
DEMETHYLCHLORTETRACYCLINE

Capsules: 150 mg; **Tablets:** film coate mg, 150 mg and 75 mg of demethylchlo cycline HCl.

LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York

Lederle

heavenly relief
for unearthly cough

Benylin®
EXPECTORANT



Each fluidounce contains: 80 mg. Benadryl® (diphenhydramine hydrochloride, Parke-Davis); 12 grains ammonium chloride; 5 grains sodium citrate; 2 grains chloroform; 1/10 grain menthol; and 5% alcohol.

An antitussive and expectorant for control of coughs due to colds or of allergic origin, BENYLIN EXPECTORANT is the leading cough preparation of its kind. BENYLIN EXPECTORANT tends to inhibit cough reflex... soothes irritated throat membranes. And its not-too-sweet, pleasant raspberry flavor makes BENYLIN EXPECTORANT easy to take.

PRECAUTIONS: Persons who have become drowsy on this or other antihistamine-containing drugs, or whose tolerance is not known, should not drive vehicles or engage in other activities requiring keen response while using this preparation. Hypnotics, sedatives, or tranquilizers if used with BENYLIN EXPECTORANT should be prescribed with caution because of possible additive effect. Diphenhydramine has an atropine-like action which should be considered when prescribing BENYLIN EXPECTORANT.

ADVERSE REACTIONS: Side reactions may affect the nervous, gastrointestinal, and cardiovascular systems. Drowsiness, dizziness, dryness of the mouth, nausea, nervousness, palpitation, and blurring of vision have been reported. Allergic reactions may occur.

PACKAGING: Bottles of 4 oz., 16 oz., and 1 gal.

Parke, Davis & Company
Detroit, Michigan 48232

PARKE-DAVIS

410R69

A once-popular treatment for back pains was to have the seventh son of a seventh son stand or walk on the patient's back.





The pain of earache was allegedly relie by holding a hot roasted onion to the ea

For headache, a sovereign remedy was to wear a snakeskin round one's head.



A realistic approach to pain relief



'Empirin'®

Compound with Codeine Phosphate gr. 1/2 No. 3

Each tablet contains:
Codeine Phosphate gr. 1/2 (Warning—May be habit forming), Phenacetin gr. 2 1/2, Aspirin gr. 3 1/2, Caffeine gr. 1/2.

keeps the promise of pain relief

'B.W. & Co.' narcotic products are Class "B", and as such are available on oral prescription, where State law permits.

BURROUGHS WELLCOME & CO. (U.S.A.) INC.
Tuckahoe, N.Y.



tones down the "explosive gut"

helps restore normal motility and tone

CANTIL®

(mepenzolate bromide)

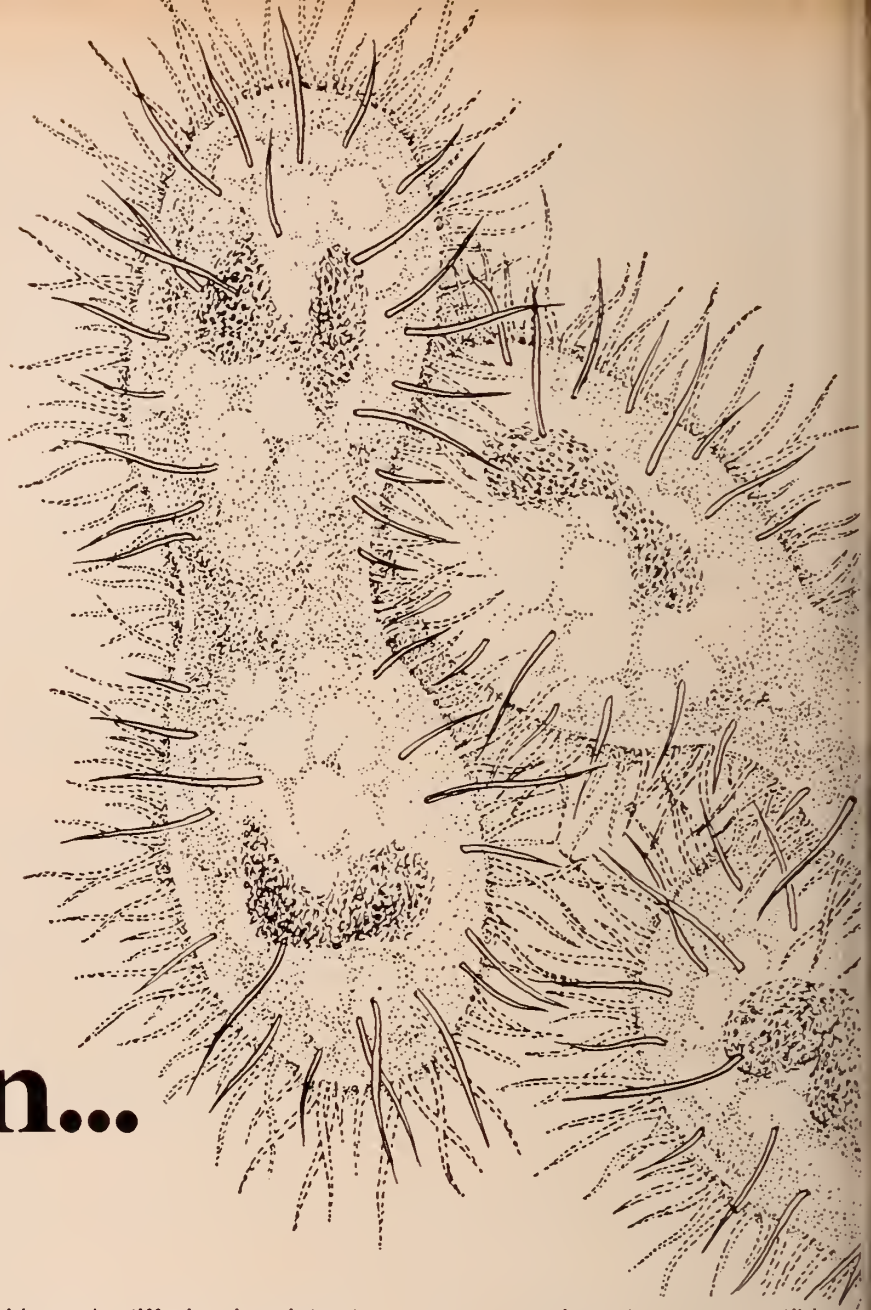
Diarrhea and other symptoms of common G.I. disorders can often be curbed with Cantil (mepenzolate bromide), bringing welcome relief to the harassed patient. Relatively specific for the hyperactive colon, it helps reduce diarrhea, pain and spasm with minimal effect on other viscera. Cantil (mepenzolate bromide) is indicated whenever these symptoms are associated with irritable colon, gastroenteritis, diverticulitis, and mild to moderate ulcerative colitis.

It is an anticholinergic drug without narcotic properties. Side effects are usually mild.

LAKESIDE

CONTRAINDICATIONS: Sensitivity to Cantil® (mepenzolate bromide), glaucoma, G.I. or G.U. obstruction, toxic megacolon. **WARNINGS:** Possibility of adverse reactions in advanced severe ulcerative colitis and atypical agitated reactions to phenobarbital in the elderly (Cantil with Phenobarbital). **PRECAUTIONS:** Cantil is of adjunctive use only; treatment of the underlying condition is indicated, be it organic or functional. Observe caution in conditions known to be incompatible with atropine-like drugs, e.g., open-angle glaucoma or prostatic hypertrophy. **ADVERSE EFFECTS:** Dry mouth; blurred vision; constipation; nausea; vomiting; bloating; dizziness; urinary retention. All are anticholinergic effects and usually tolerable. Habituation and idiosyncratic reactions to phenobarbital (Cantil with Phenobarbital) are possible, as is generalized rash. **DOSAGE:** One or two tablets three times a day and one or two at bedtime usually provide prompt relief. Cantil with Phenobarbital may be prescribed if sedation is required. **HOW SUPPLIED:** CANTIL (mepenzolate bromide)—25 mg. per scored tablet. Bottles of 100 and 250. CANTIL with PHENOBARBITAL—containing in each scored tablet 16 mg. phenobarbital (warning: may be habit forming) and 25 mg. mepenzolate bromide. Bottles of 100 and 250.

LAKESIDE LABORATORIES, INC., Milwaukee, Wisconsin 53201



A high index of suspicion... E. coli

How high is the "index of suspicion" for *E. coli* in urinary tract infections?

Recently it has been estimated that about 86 per cent of positive cultures in first attacks of urinary tract infection are *E. coli*.[1] It has also been noted that "The coliform group, especially *E. coli*, accounts for approximately 90 per cent of initial infections...."[2]

Consider wide-spectrum Gantanol® (sulfamethoxazole) for its high "index of confidence"—its proven effectiveness against *E. coli* and other sensitive gram-negative and gram-positive organisms. Therapeutic levels of Gantanol in blood and urine are achieved within 2 hours after a 2-Gm starting dose, with ready diffusion into interstitial fluids. Responsive infections generally clear within 5 to 7 days, with relief of symptoms usually seen within 24-48 hours.

Gantanol also earns its high "index of confidence" because Gantanol therapy is relatively free from complications, including the problem of bacterial resistance or superinfection.

Convenient, economical dosage schedule: *b.i.d.*

References: 1. Vernier, R. L., in Patient Care Feature: *Patient Care, 1*:20 (Feb.) 1967. **2.** Beeson, P. B.: "The Infectious Diseases," in Beeson, P. B., and McDermott, W. (eds.): *Cecil-Loeb Textbook of Medicine*, ed. 12, Philadelphia, W. B. Saunders Company, 1967, p. 230.

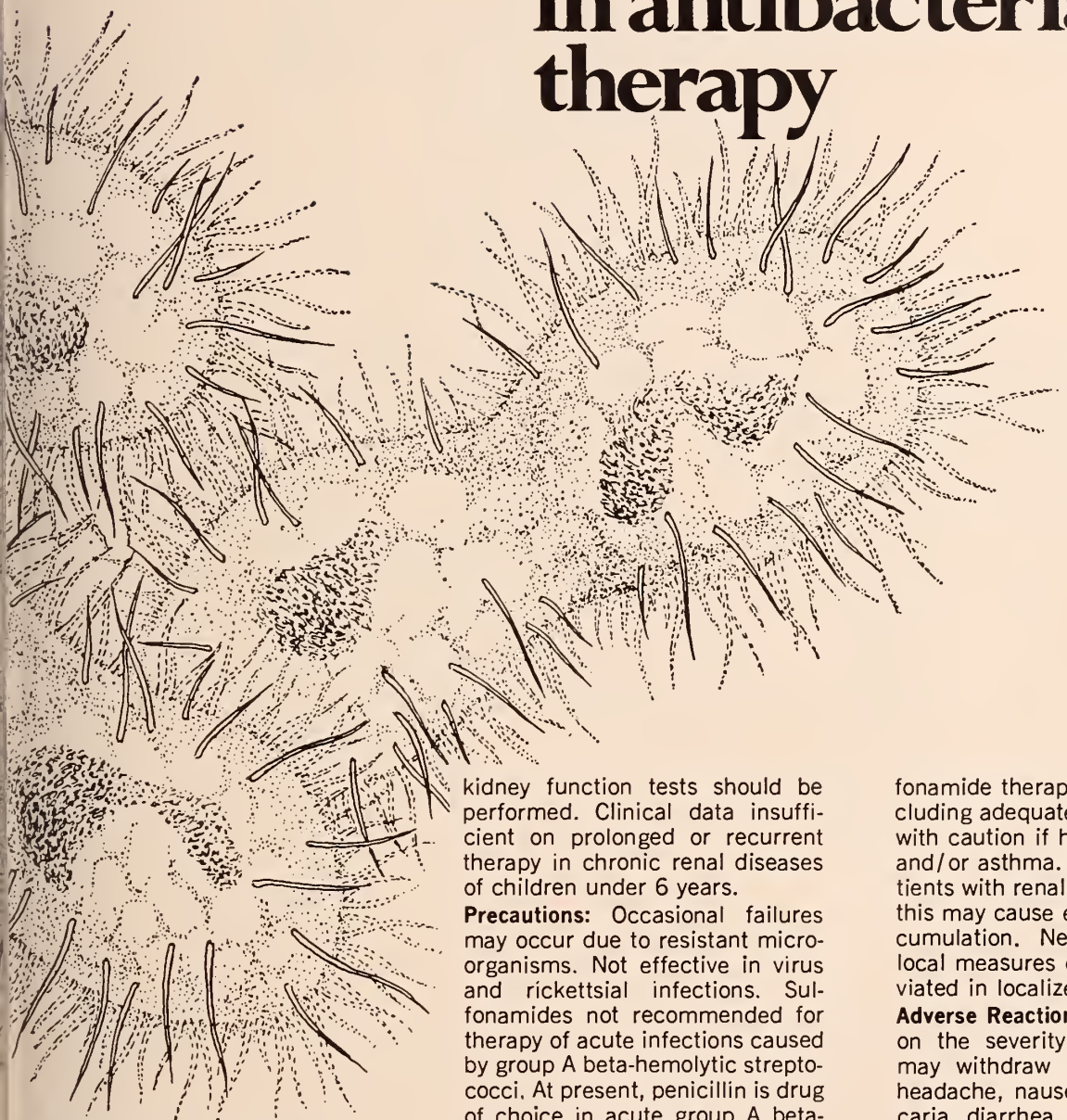
Before prescribing, please consult complete product information, a summary of which follows:

Indications: Acute and chronic urinary tract, respiratory and soft tissue infections due to susceptible microorganisms; prophylactically following diagnostic instrumental procedures on genitourinary tract.

Contraindicated in sulfonamide-sensitive patients, pregnant females at term, premature infants, or newborn infants during first 3 months of life.

Warnings: Use only after critical appraisal in patients with liver or renal damage, urinary obstruction or blood dyscrasias. Deaths reported from hypersensitivity reactions, Stevens-Johnson syndrome, agranulocytosis, aplastic anemia and other blood dyscrasias. In closely intermittent or prolonged therapy, blood counts and liver and

For a high index of confidence... Gantanol® (sulfamethoxazole) in antibacterial therapy



Artist's rendition of E. coli. As with most strains of E. coli, these have flagella and are motile.

kidney function tests should be performed. Clinical data insufficient on prolonged or recurrent therapy in chronic renal diseases of children under 6 years.

Precautions: Occasional failures may occur due to resistant microorganisms. Not effective in virus and rickettsial infections. Sulfonamides not recommended for therapy of acute infections caused by group A beta-hemolytic streptococci. At present, penicillin is drug of choice in acute group A beta-hemolytic streptococcal infections; although Gantanol has produced favorable bacteriologic conversion rates in this infection, data insufficient on long-term follow-up studies as to its effect on sequelae of rheumatic fever or acute glomerulonephritis. If other treatment cannot be used and Gantanol is employed in such infections, *important that therapy be continued in usual recommended dosage for at least 10 days*. Observe usual sulfonamide therapy precautions, including adequate fluid intake. Use with caution if history of allergies and/or asthma. Follow closely patients with renal impairment since this may cause excessive drug accumulation. Need for indicated local measures or surgery not obviated in localized infections.

Adverse Reactions: Depending upon the severity of the reaction, may withdraw drug in event of headache, nausea, vomiting, urticaria, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, Stevens-Johnson syndrome, skin rash, injection of the conjunctiva and sclera, petechiae, purpura, hematuria and crystalluria.

ROCHE

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Division of Hoffmann-La Roche Inc.
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To fight TB- find it first!

Make tuberculin testing routine with every physical examination.



TUBERCULIN, TINE TEST (Rosenthal)

Side effects are possible but rare: vesiculation, ulceration, or necrosis at test site. Contraindications: none, but use with caution in active tuberculosis. Available in 5's and 25's.

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ASHEVILLE, NORTH CAROLINA

Founded 1904

A DIVISION OF THE DEPARTMENT OF PSYCHIATRY OF DUKE UNIVERSITY

Accredited by the Joint Commission on Accreditation and Certified for Medicare

Complete facilities for evaluation and intensive treatment of psychiatric patients, including individual psychotherapy, group therapy, psychodrama, electro-convulsive therapy, Indoklon convulsive therapy, drugs, social service work with families, family therapy, and an extensive and well organized activities program, including occupational therapy, art therapy, athletic activities and games, recreational activities and outings. The treatment program of each patient is carefully supervised in order that the therapeutic needs of each patient may be realized.

High school facilities for a limited number of appropriate patients are now available on grounds. The School Program is fully integrated into the hospital treatment program and is accredited through the Asheville School System.

Complete modern facilities with 85 acres of landscaped and wooded grounds in the City of Asheville.

Brochures and information on financial arrangements available

Contact: Mrs. Elizabeth Harkins, ACSW, Coordinator of Admissions

or

Charles W. Neville, Jr., M.D.

Assistant Professor of Psychiatry and Medical Director

Area Code 704-253-2761



"The inconvenience of a cold"

or a cold, NTz® Nasal Spray provides rapid relief of asal symptoms. Relief starts with the first spray which pens the inferior part of the common meatus. A second pray, a few minutes later, will shrink the turbinates to elp provide sinus drainage and ventilation. Dosage ay be repeated every three or four hours as needed, r temporary relief of symptoms. NTz is well tolerated it overdosage should be avoided.

a sinusitis deterrent, NTz Nasal Spray can be used to eep the nasal passages open during a cold to help pre- nt development of acute sinusitis—or to help prevent e acute condition from becoming chronic.

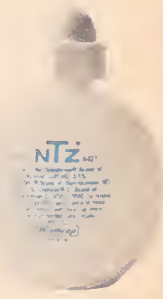
pplied: NTz Nasal Spray, plastic squeeze bottles of ml.; NTz Nasal Solution, bottles of 30 ml. (1 fl. oz.) th dropper.

NTz is more than a simple vasoconstrictor. It contains

Neo-Synephrine® (brand of phenylephrine) HCl 0.5 per cent, the major component, virtually synonymous with fast, efficient but gentle nasal vasoconstriction.

Thenfadil® (brand of thenyldiamine) HCl 0.1 per cent, topical antihistamine for reduction of rhinorrhea, sneezing or itching. It combats the allergic reactions that may occur in colds or sinusitis.

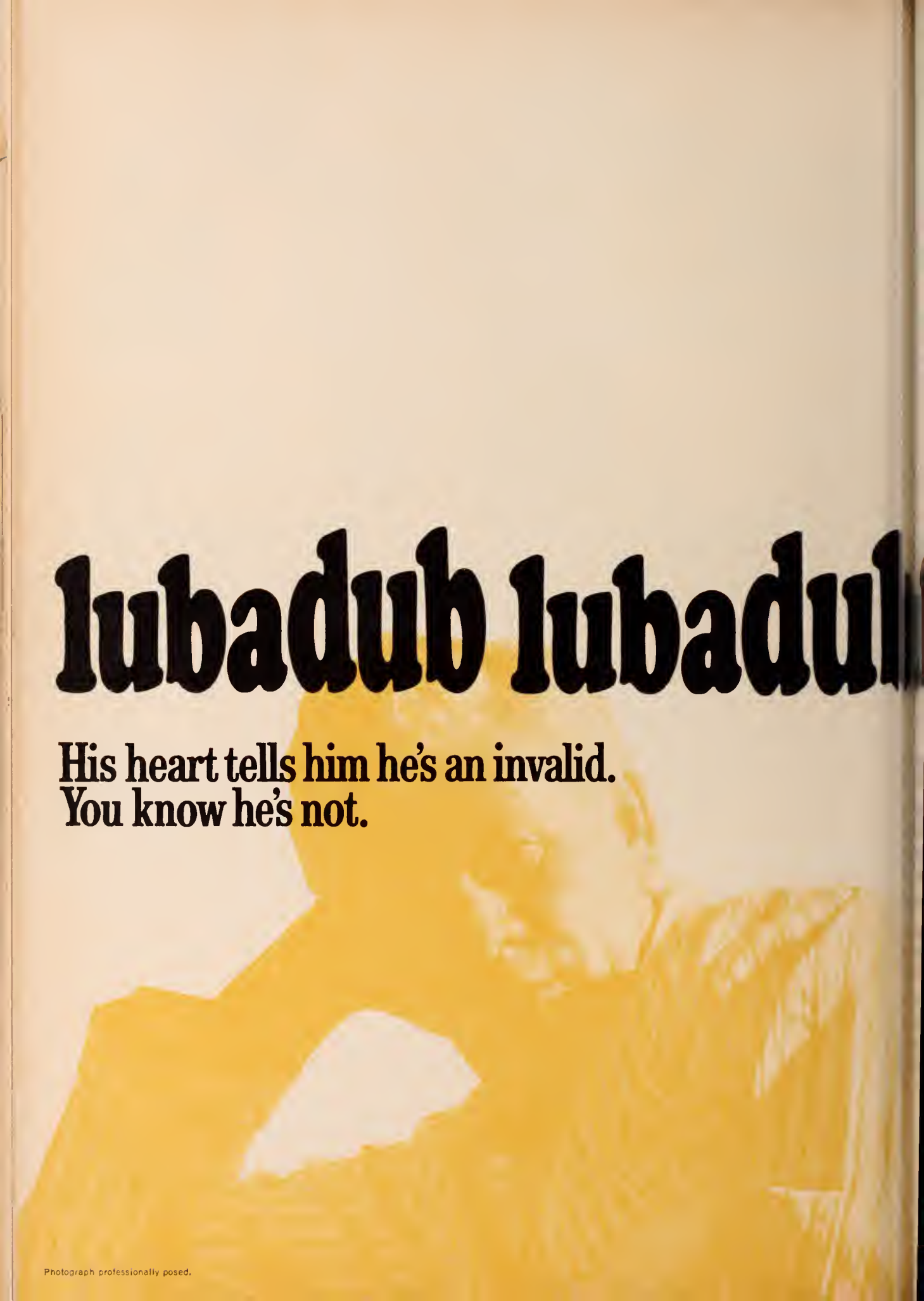
Zephiran® (brand of benzalkonium, as chloride, refined) 1:5000, antiseptic preservative and wetting agent to promote penetration and spread of the formula.



Winthrop Laboratories, New York, N.Y. 10016 Winthrop

lubadub lubadub

His heart tells him he's an invalid.
You know he's not.



Photograph professionally posed.

Contraindications: History of sensitivity to meprobamate.

Important Precautions: Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use has been reported to result in dependence or habituation in susceptible persons, as alcoholics, ex-addicts, and other severe psychoneurotics. After prolonged excessive dosage, reduce dosage gradually to avoid possibly severe withdrawal reactions. Abrupt discontinuance of excessive doses has sometimes resulted in epileptiform seizures.

Warn patients of possible reduced alcohol tolerance, with resultant slowing of reaction time and impairment of judgment and coordination.

Reduce dose if drowsiness, ataxia or visual disturbance occurs; if persistent, patients should not operate vehicles or dangerous machinery.

Side Effects include drowsiness, usually transient; if persistent and associated with ataxia, usually responds to dose reduction; occasionally concomitant CNS stimulants (amphetamine, mephentermine sulfate) are desirable. Allergic or idiosyncratic reactions are rare, but such reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Previous history of allergy may or may not be related to incidence of reactions. Mild reactions are characterized by itchy urticarial or erythematous maculopapular rash, generalized or confined to groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. One fatal case of bullous dermatitis following intermittent use of meprobamate with prednisolone has been reported. If allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Treat symptomatically as with epinephrine, antihistamine and possibly hydrocortisone. Aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia have occurred rarely, almost always in presence of known toxic agents. A few cases of leukopenia usually transient, have been reported on continuous administration.

Meprobamate may sometimes precipitate grand mal attacks in patients susceptible to both grand and petit mal. Extremely large doses can produce rhythmic fast activity in the cortical pattern. Impairment of accommodation and visual acuity has been reported rarely. After excessive dosage for weeks or months, withdraw gradually (1 or 2 weeks) to avoid recurrence of pretreatment symptoms (insomnia, severe anxiety, anorexia). Abrupt discontinuance of excessive doses has sometimes resulted in vomiting, ataxia, tremors, muscle twitching and epileptiform seizures. Prescribe very cautiously and in small amounts for patients with suicidal tendencies. Suicidal attempts have resulted in coma, shock, vasomotor and respiratory collapse and anuria. Excessive doses have resulted in prompt sleep; reduction of blood pressure, pulse and respiratory rates to basal levels; and occasionally hyperventilation. Treat with immediate gastric lavage and appropriate symptomatic therapy. (CNS stimulants and pressor amines as indicated.) Doses above 2400 mg./day are not recommended.

Composition: Tablets, 200 mg. and 400 mg. meprobamate. Coated Tablets, WYSEALS® EQUANIL (meprobamate) 400 mg. (All tablets also available in REDIPAK® [strip pack], Wyeth.) Continuous-Release Capsules, EQUANIL L-A (meprobamate) 400 mg.

Wyeth Laboratories Philadelphia, Pa.

,badubdub lubadu

Xiety is expected in the cardiovascular patient.
Ittle may even be desirable.

Bt when anxiety is exaggerated . . . when it
erferes with sleep . . . when it aggravates
diovascular symptoms, your help may
needed.

Nturally, you'll want to reassure the patient.

Ad perhaps prescribe Equanil (meprobamate)
adjunctive therapy. It helps relieve anxiety
d tension specifically, yet gently.

Most 15 years' use has shown that Equanil
usually well tolerated as well as effective.
Se effects are generally limited to transient
wsiness; serious, therapy-interrupting
e effects are rare.

Equanil®
(meprobamate) Wyeth®



The two-stage power of the pink pill for U.R.I. symptoms is nothing to be sneezed at.

The immediate and continuous-release actions built into each Novahistine Singlet can give most of your patients prompt and long-lasting relief from symptoms of upper respiratory infection, including fever, aches and pains.
Not only does Novahistine Singlet provide a vasoconstrictor-antihistamine formulation to reduce congestion and help restore normal ciliary activity; it also contains an antipyretic-analgesic compound to relieve the fever, aches and pains that so frequently accompany upper respiratory infections.
A total daily dosage of 3 or 4 tablets will normally provide the continuous relief your patient expects. Use with caution in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result.

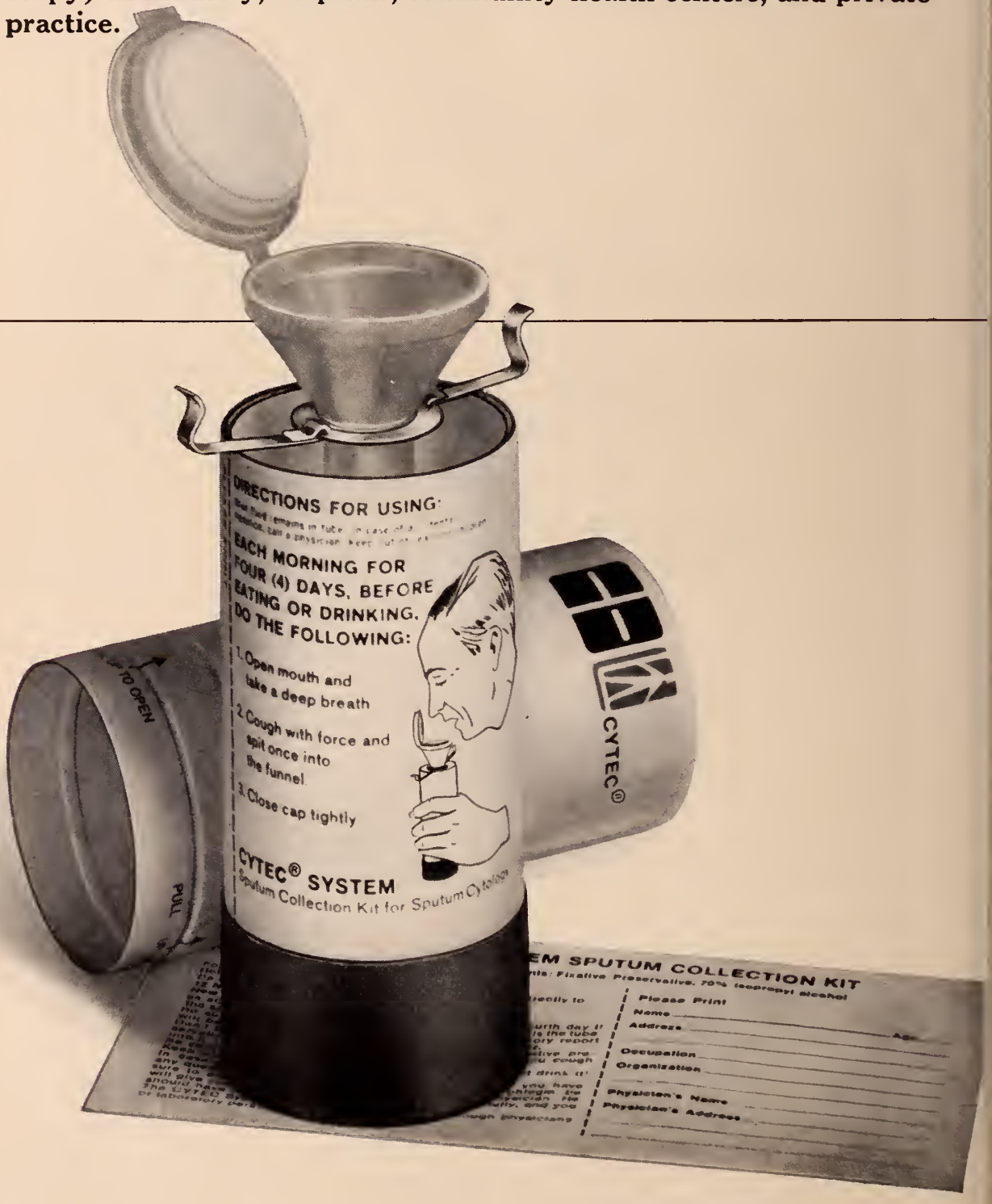
Pitman-Moore Division of
The Dow Chemical Company,
Indianapolis, Indiana.

Novahistine®
Singlet decongestant-analgesic
(Each tablet contains: phenylephrine hydrochloride, 40 mg.; chlorpheniramine maleate, 8 mg.; acetaminophen, 500 mg.)

DOW

AN IMPORTANT MESSAGE ON SPUTUM CYTOLOGY

Sputum Cytology—practical and economical as a routine diagnostic aid for the detection of lung cancer to be used in conjunction with other diagnostic techniques (such as roentgenology and bronchoscopy) in industry, hospitals, community health centers, and private practice.



AN AID TO THE MEDICAL COMMUNITY: Sputum cytologic screening is an aid in lung cancer detection when used with professional judgment as part of the diagnostic workup of the patient.

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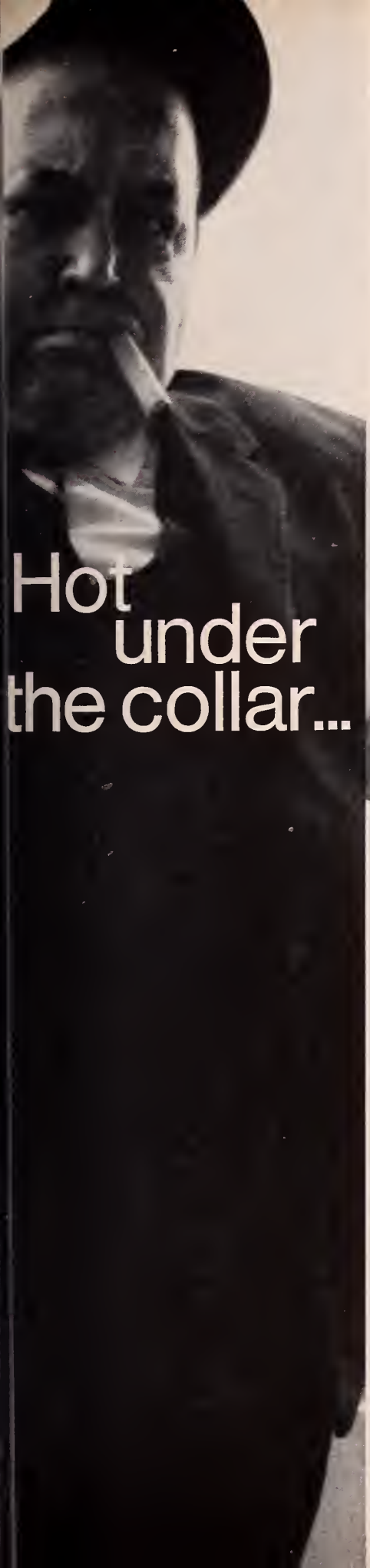
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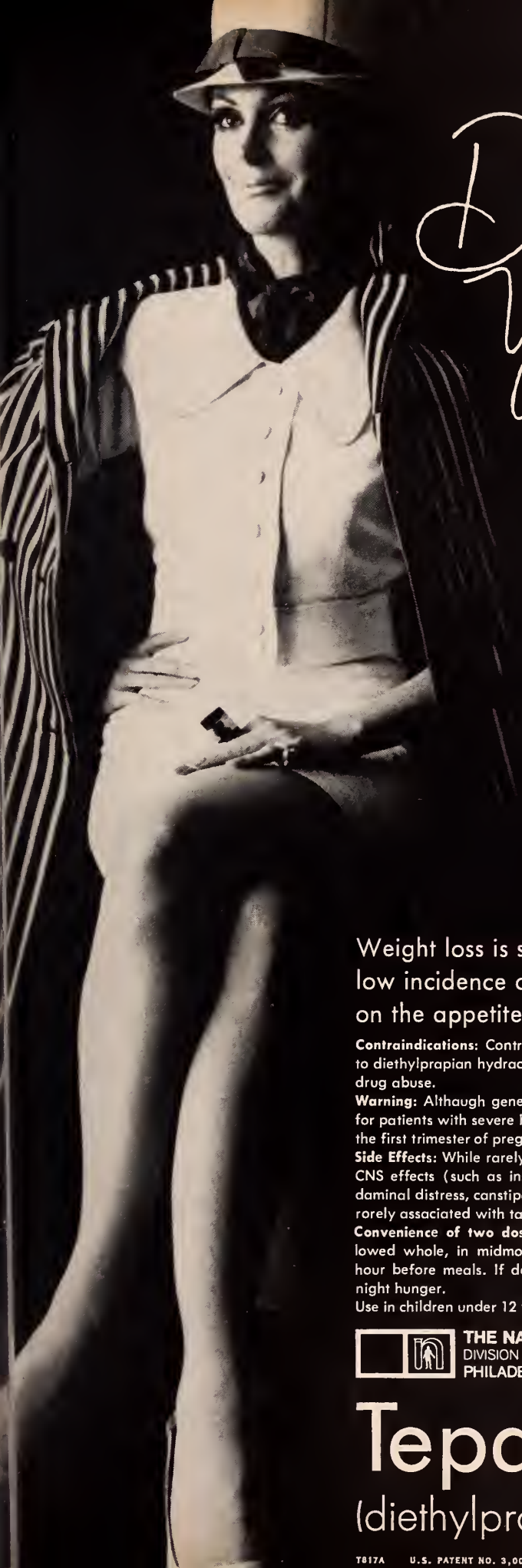
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Precautions: Use cautiously, if at all, in a patient with a strongly positive history of allergy.

In prolonged therapy with penicillin, and particularly with high parenteral dosage schedules, frequent evaluation of the renal and hematopoietic systems is recommended.

In suspected staphylococcus infections, proper laboratory studies (including sensitivity tests) should be performed.

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EDITORIALS

The University Hospital As A Scapegoat

The newest weapon in the armory of the hospital critics is the book, *Sickness and Society* by R. S. Duff and A. B. Hollingshead, published recently by Harper and Rowe. The thrust of their argument is that the large hospitals and the university affiliated medical centers have become so enchanted by research that they are less interested in the care of the patient.

The book asserts that there is a cleavage between the physician who identifies essentially with the medical school and the clinician in private practice who is granted staff privileges in return for doing free time at the clinics. Ward patients, say the authors, are admitted only for their teaching or research value. It is suggested that these patients are "so much clinical material, rather than human beings."

There is also the indictment that doctors, particularly those in an academic setting, are not much interested in the emotional factors in physical illness. This seems odd, since psychosomatic medicine has never been stressed so strongly as it has in the past twenty years. There is also the allegation that dying patients are shut off from meaningful communication with the doctor, who dismisses them as of no further interest.

Most hospital physicians will probably deny these charges, or at least insist that they are seriously exaggerated. It is also true that a book like this does hurt; it undermines the patients' confidence in the institutions that are supposed to save lives. Needless to say, the text traumatizes the families of patients. But is also provides all of us an opportunity to show that it is not so. The emphasis should be on the fact that modern medical teaching institutions actually do save lives, and that the intellectual stimulation of research and teaching will in the long run provide the best patient care.

A Doctor In The Family?

If you aspire to have a doctor in your family, your *eldest* son may turn out to be the one who aims for a medical career. In fact, the eldest may be most likely to enter medical school, particularly if he has several brothers and sisters.

These are some of the findings of a report by two staff members of the Institute for Social Research at the University of Michigan. It is based on a survey of the class of 1968 at the university's School of Medicine.

When the 207-member class entered medical school in 1968, it contained 2½ times as many *eldest* sons of families as youngest sons, the report said. It might be further assumed that the influence is most strong on the first-born son, and is projected less strongly on each younger son. An alternative is that "frustrated fathers project their occupational aspirations equally on all sons," but the sons accept varying amounts of this influence according to their order in the family.

Another possible explanation is that "families who send their first-born son to medical school have spent so much on education that they cannot afford to send their last born, especially if they have many children." No evidence of this was found, however. There was a high ratio of eldest-son medical students in even the highest income groups. "Thus, the observed effects seems to be related more to the motivations of the sons than to the pocketbooks of their fathers." If these preliminary findings are confirmed, "one will be led to the general conclusion that entrance into medical school is strongly influenced by family relationships."

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Actually there are some psychologic factors here that seem strangely soft-pedaled in this survey. It would seem obvious that a career must be a satisfying one if a father wants to pass it on to his son. Then, too, the eldest son is traditionally the heir anyway, so that the transmission to him becomes "natural", at least in our Western culture. It is too bad that the researchers didn't also find out about eldest daughters, especially when they were senior to the sons. One wonders also about the frequency with which physician's daughters marry doctors.

The October 1967 issue of this JOURNAL published a paper (64:560) on "The Physician as a Parent." Here it is pointed out that "Physicians tend to be aggressive men. Weak, passive ones are usually screened out by college and medical school. Any milktoasts who survive are likely to avoid the highly competitive arena of private practice and to seek quieter pastures of research, government medicine, or teaching. Thus, there is a high titer of strong men among private practitioners. However, this does not mean that the aggressive man is going to have a timid wall-flower of a wife. Many wives are determined little creatures in their own right, and some of them lead "bossy" husbands around the way a little tugboat guides a giant liner. But inevitably, in many medical households, Poppa cracks the whip. Often the household schedule has to turn on the axis of *his* professional needs. This may make for a smooth running household machine but it may also lead to dominated children. The child who chafes under this kind of dominance may react in one of three ways. He becomes meek and fearful; or he withdraws into a world of make-believe where things are better; or he becomes sullen. This is one of the occupational hazards of medical fatherhood."

Counterpointing the "like-father-like-son" pattern is the pattern of reversal—the college athlete who in later life deplores the fact that he neglected his studies for sports. Now, in middle age, he loses ground because no one seems to have much need for a man who, 30 years ago had been an All-American quarterback. So he determines grimly that *his* son will be an intellectual. He downgrades sports and enriches his son's curriculum with intellect. Sonny boy grows up to be a bookworm. At college he stands on the sidelines while the glamour girls swoon over the athlete. The sportsman is graduated and sixteen brokerage firms bid for him. Sonny boy now swears a mighty oath. If he has a son, *that* boy will be no bookworm. No sir, he will be an athlete.

Ordinarily this cycle does not develop in doctors' families. But occasionally it does. The physician sees that money rewards go to big business men. He learns that the magnetic careers today are not in medicine but in nuclear physics or engineering. So, in rare cases, he steers his son away from the toil and trouble of medicine; and then not until he has grandchildren is there another M.D. in the family.

Much more often however, the physician wants his son to be an M.D. In fact you would be surprised at how often a doctor dreams of founding a medical dynasty. If he is the first of his family to be an M.D. he hopes to be the charter member of such a clan. If he is the son or nephew of a physician, he does not want to break the chain. As a result, there are complex and burgeoning medical families in every large city, in most small ones, and in many famous "name" clinics. Though he may protest that he has no such interest, the dynastic dream often tinctures a physician's attitude toward parenthood.

Some of us swear at ourselves and wonder why we ever entered such a profession—heavy responsibilities, unending hours, and, in the last decade, being the target of constant criticism. We have been called arrogant, greedy, unfeeling, and lots of other dirty words. "Why, oh, why," we sometimes say, "did I ever study medicine!" But our real feelings come out in the way we try to influence our children.

And in spite of all the tribulations and criticisms, most of us, if we had to do it over again, would opt for the same profession if we ever had a second time around.

ORIGINAL ARTICLES

Subglottic tracheal tumors are rare enough to be well worth reporting. Here are two hamartamatous tumors — an even rarer phenomenon.

Management Of Benign Tumors And Obstructions Of The Subglottic Trachea*

Nicholas J. Demos, M.D. and Joseph J. Timmes, M.D./Jersey City

Segmental tracheal resection, up to six or seven rings, and end-to-end anastomosis is a feasible and adequate treatment for benign strictures or benign and malignant neoplasm.[5] The proximity, however, of the uppermost one inch of the trachea (subglottic area) to the superior and the recurrent laryngeal nerves makes this area inaccessible and hazardous for full thickness resectional therapy, if the laryngeal functions are to be preserved. The subglottic area is the most narrow part of the entire trachea, even though the bony skeleton is widest at that point. Its cone-shaped narrowness is produced by the thyro-arytenoid muscles and other soft tissue lying inferior to the true vocal cords. Consequently, resection of mucosal or submucosal lesions resulting in even the slightest amount of scar, produces varying degrees of stenosis or complete obstruction.

This is a report of successful resection of two subglottic tumors with subsequent successful management of the resulting strictures. A different method was employed in each case to correct the post-operative stricture.

Case One

A 50 year old woman was brought to Pollak Hospital for Chest Diseases in severe dyspnea and cyanosis. Emergency tracheostomy relieved her symptoms. Direct laryngoscopy revealed a subglottic lobulated mass completely obstructing the entrance to the trachea. The intrinsic larynx was also very edematous with considerable loss of the usual anatomic landmarks. Biopsy revealed "fibro-angiomatous" tracheal nodule which could be a hamatoma. (Figure 2) She was transferred to the ear, nose, and throat service were she underwent a laryngofissure operation and resection of the subglottic obstructing lesion. We saw the patient seventeen months later. She still breathed only through the initial tracheostomy. She was unable to breathe through the mouth or nose, she was unable to speak, and she had developed a self-taught, whispering esophageal speech. Direct laryngoscopy revealed a normal larynx, including the vocal cords, but complete obstruction of the subglottic area, (Figure 1). Biopsy revealed inflammatory tissue. Within the space of five months she underwent ten dilatations up to size 36 French olive-tipped dilator. A complete obstruction recurred each time.

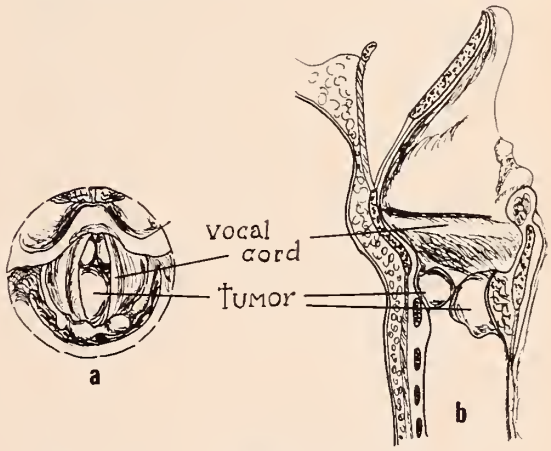


Figure 1

a. Endoscopic view of subglottic tumor.
b. Lateral view of hemisection of larynx showing the subglottic tumor in Case 1.

* From the Departments of Surgery, New Jersey College of Medicine, and the B.S. Pollak Hospital for Chest Diseases, Jersey City. This work was aided by grant HE 5631-04 of the U.S. Public Health Service. Dr. Demos is Assistant Professor of Surgery and Dr. Timmes is the Professor of Surgery.

After an additional gradual dilatation up to 36 French dilator, under general anesthesia administered through the tracheostomy, an especially constructed obturator was endoscopically inserted in an infraglottic position (Figure 3). A segment of extruded pure Teflon rod, half an inch in diameter, was cut long enough so that its inferior end was in contact with the tracheostomy tube and the superior end almost touched the true vocal cords. These estimates were made by consulting a lateral soft tissue roentgenogram of the neck.

Several holes were made in the teflon rod in order to fix it with a number 00 stainless steel wire inserted through the skin and muscles, the tracheal wall, the rod, and again through the trachea and the skin. The wire was tied after its external part was covered with a rubber boot.

Every week, the position of the obturator was checked with an x-ray (Figure 4). Finally, it was removed in 22

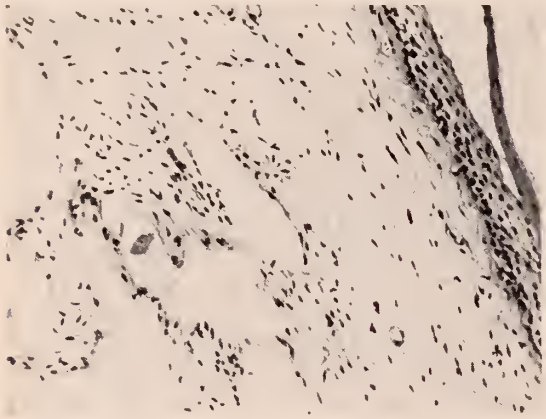


Figure 2

Fibro-angiomatous nature of tumor in case 1.

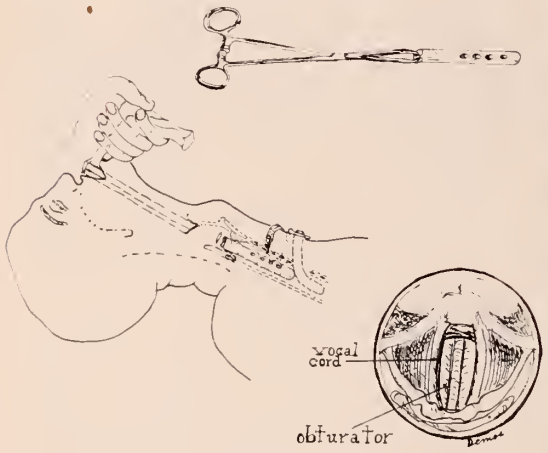


Figure 3

Technic of insertion and fixation of obturator to relieve subglottic stricture in case 1.

days and a good size infraglottic opening was observed. Two weeks later endoscopy revealed a good lumen with a smooth lining admitting easily an 8 millimeter bronchoscope. She gets along well without her tracheostomy, and for the first time in one and half years, she has normal, though somewhat hoarse speech. She continues to do well over six months postoperatively (Figure 5). Monthly endoscopies reveal that an 8 mm. bronchoscope passes very comfortably through the previously strictured area.



Figure 4

Lateral x-ray of neck with the obturator in position, case 1.



Figure 5

Lateral neck x-ray of case 1 with adequate subglottic airway after removal of the obturator.

Comment

Teflon is the least reactive material available to us today. This is a highly desirable quality since the obturator remains in contact with inflamed tissues for 20 to 30 days. Another advantage of Teflon is that it is soft enough to be easily curved with a pocket knife; and it is less likely to erode into the neighboring tissues. In experiments we performed ten years ago[1] we found that around the Teflon rod imbedded in the pleural cavity of dogs, there forms a cylinder of tissue with an extremely smooth lining. This concept led us to use Teflon.

The wire fixing the Teflon obturator in position not only prevents up or down displacement but also keeps the obturator anteriorly thus avoiding possible erosion into the esophagus.

Case Two

A 55 year old woman with a hoarse voice entered Jersey City Medical Center complaining of anorexia and weight loss. She had had retrosternal pain for two weeks and had vomited some clotted blood two days prior to admission. She had talked with a hoarse voice since childhood. The patient was a "sociopathic" personality. She would not allow esophagoscopy under topical anesthesia. Attempts at endotraceal intubation were unsuccessful, because of a hard, unyielding subglottic mass obstructing over 90 per cent of the lumen (Figures 6 and 7). Esophagoscopy under general anesthesia revealed squamous carcinoma of the lower half of the esophagus. Biopsy of the subglottic lesion yielded a few small pieces diagnosed as normal mucosa. After appropriate preoperative preparation and through separate abdominal and right posterolateral thoracotomy incisions esophagectomy and a high esophago-gastrostomy were performed. An intercostal pedicle from the third intercostal space was sutured around the anastomosis to prevent gastro-esophageal reflux according to the method developed by us.[2]

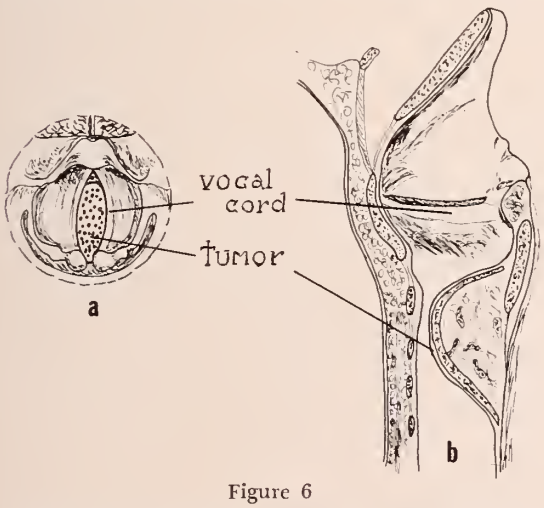


Figure 6

a. Endoscopic view and
b. Lateral view of hemisected larynx, both showing the subglottic hamartoma of case 2.



Figure 7

See encroachment of the subglottic air column by the hamartoma, case 2.

One month postoperatively, a laryngofissure was performed under general anesthesia, administered through the tracheostomy. The cricoid cartilage was also divided for adequate exposure. A bony vascular mass† with a broad base posteriorly, (Figure 6) was resected submucosally after incising the overlying mucosa vertically. The submucosa was then sutured posteriorly with five interrupted chronic catgut sutures, and the larynx and cricoid cartilages were similarly sutured anteriorly. The wound was closed in layers. The tracheostomy was left in plate. The histologic diagnosis was osteochrondroma or hamartoma of the trachea (Figure 8). Postoperatively, the patient did well but could not talk. Several subglottic dilatations were performed endoscopically with olive-tipped dilators under general anesthesia. Several weeks later she began to regain her voice. She then was discharged. Sixteen months later, she has a good laryngeal airway and a good voice. She is psychologically dependent on the tracheostomy and she refused its removal. Lateral x-ray of the neck also reveals adequate subglottic airway (Figure 9).

† In centimeters, the dimensions of the mass were 3 by 2 by 1½.

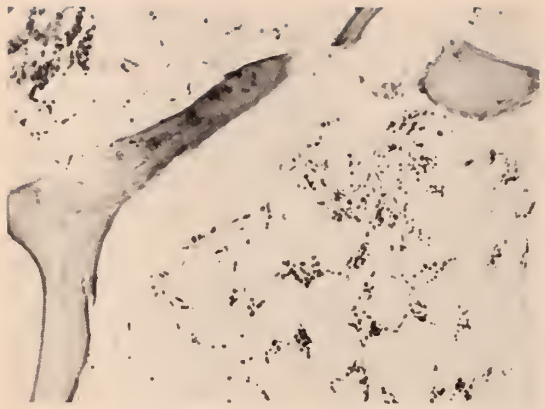


Figure 8

Osteoid tissue and bone marrow of the hamartoma of case 2.



Figure 9

See improvement of subglottic airway in case 2, compared to preoperative appearance in Figure 7.

Comment

In this patient, several dilatations through the laryngoscope were adequate to obtain a good airway. If the stricture persisted we would have used the Teflon obturator.

The rarity of subglottic tracheal tumors should be emphasized as well as the special therapeutic problems presented by tumors in this location.

If the two tumors are accepted as a hamartomata they are the second and third ones reported in the trachea since 1959.[4] The descriptive histologic term of the first tumor reported here is angiofibroma. As Jackson and Jackson,[7] however, have pointed out several years ago, some pathologists might classify similar tumor-like growths as inflammatory. Certainly in our first case, inflammation was a part of the histopathology of the lesion. The second tumor could be called an osteo-chondroma of the trachea. However, it fits the definition of a hamartoma as well. Both tumors are histologically and clinically benign. However, they grew in such a strategic location that they could kill the patient, which, indeed the first tumor almost did.

Repeated dilatations have not met with success in relieving well established tracheal stricture.[6] They should, however, be the first line of attack in postoperative strictures of the subglottic area. It seems that if the stricture is of recent origin (as in our second case) the fresh adhesions can be broken and patency maintained after several dilatations. Long term obstructions, however, as was the case in the first patient (18 months postoperatively) cannot be relieved by dilatations. The desmoplasia in the old obstructions has been well established and obstruction recurs after each dilatation. That is the reason the dilatation has to be maintained continuously through some method for at least three to four weeks, since this is the time in which soft tissue seems to heal adequately.[8] Teflon was used because it is the least reactive soft plastic material known to us. The method of insertion used in our case is simple and does not necessitate an open operation on the trachea contrary to other methods previously described.[3] The method of fixation of the prosthesis with a percutaneous wire is simple and effective and well tolerated by the patient.

Summary

Two rare hamartomatous tumors of the subglottic trachea are described. The benign na-

ture (but potential lethality) of the lesions is stressed. The special operative limitations and postoperative tendency for stricture formation are described. Successful management of postoperative obstruction was achieved by the use of two different technics each suited to each case.

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Toward A Safer Automobile

Fifty per cent of the persons currently being killed in automobiles are dying under potentially survivable conditions, even though the crash occurred. Paul W. Gikas, M.D., pathologist and authority on automobile crash injuries, discussed this tragedy at a public meeting sponsored by the Northern New Jersey Interprofessional Council.

Dr. Gikas was the medical expert for Ralph Nader in his investigation of automobile accidents. He has pointed out that the greatest area of violence and breakdown of law and order in our country is on our highways, yet there is a shocking amount of apathy toward the problem.

Some 52,000 Americans are put to death each year in highway crashes, and more people are killed in one year than were killed in the entire Korean war. From the American Revolution to the present war, all American combat deaths total less than one million. Eight years ago we passed the one-million mark in highway fatalities and are on our way to two million. Highway accidents are the number one killer in this country of persons between the ages of one and 34.

The seat belt is the greatest single available step to save your life in a car crash, says Dr. Gikas. A recent Swedish study showed that no death occurred in accidents at speeds up to 60 m.p.h. where both seat and shoulder belts were used.

Dr. Gikas and his co-author, Donald F. Huelke, Ph.D., stated that after a four-year study of 139 automobile accidents, in which 177 occupants died, ejection of the occupant from the car was the leading cause of death. At least 50 per cent of the drivers at fault had been drinking prior to the collision. Compromising of the passenger compartment and impact with the steering assembly and instrument panel ranked high as causes of fatalities. Needed now is a concentrated effort to educate passengers as well as drivers to use seat belts. We also need serious effort for safer highway and off-roadway designs, and adequate legislation and enforcement to help prevent the first collision.

The public has never been given the opportunity to make a selection of an automobile based on knowledge of safety features and performance. Style and safety are not mutually exclusive. Some of the features to look for in a comparatively safe car today are: engine in front; a full-size, heavier car; energy absorbing steering assembly; head rests; restraining systems including shoulder belts; absence of protrusions and gimmicks inside the car; and the best tires available.

A well-organized, always available, suicide prevention telephone service has already saved lives in southern New Jersey.

Organization Of A Suicide Prevention Center*

Harry H. Brunt, Jr., M.D./Hammonton

". . . . I have had emotional problems all of my life. Some of them have been a source of spiritual conflict and despair. . . ."

"There must be others like me who feel alienated, cut off from God, from a religion that seems to offer no help for their problems, their conflicts, their agonies. . . ."

Here are two personal experiences in seeking help in a disturbed state.

1. "I felt the need for spiritual help during a crisis. I traveled by bus to (a church) in Philadelphia hoping they would be having confessions at that time of day. They were, but unfortunately the priest stuttered and seemed nervous himself. Impatient people waiting opened the door to see if the box was empty. Who could be taking so long? A fiasco."

2. "This time an emotional earthquake. Had to get some help. Where? Being a person of foresight I had written down the Suicide Prevention phone number when it had appeared in the newspaper some time previously. I called and was immediately connected with a psychiatrist who talked at length with me, told me what to do, and asked me to be sure to call back later and tell him how I was doing. This time I had done the right thing.

"Two things are important here. First, the source of help was qualified. Second, I felt that he cared. Also, I did not get the feeling that I was holding him back from doing something that was more important to him. This on-the-spot emergency help was part of his job.

"I submit that the person who has a spiritual-emotional crisis needs on-the-spot help."

None of what I have said are my words, of course. They are the quoted words of a despair-filled person who called the Ancora Suicide Prevention Telephone Service and are excerpted from her letter to the Editor which appeared in a southern New Jersey paper. Prior to February 3, 1966 such a service would not have been available to the troubled caller, for it was on that date that Ancora State Hospital inaugurated its Suicide Prevention Telephone Service.

The previously quoted excerpts from the letter of a potentially suicidal caller—along with the numerous, similar calls over the past two years—serve to indicate how Ancora's relatively new anti-suicide role has filled to an appreciable degree a recognized vacuum in handling crisis-ridden situations for the citizenry of southern New Jersey.

As Medical Director of the first and only State psychiatric hospital in this seven-county area since November 1954, I became increasingly aware of this vacuum in which a "cry for help" would go unheard. Numerous inquiries concerning suicide came into the hospital throughout its brief history since its opening in April 1955. A wealth of informational requests were directed to us from deeply concerned relatives and friends of those

*Read before the Special Scientific Session on Suicide, Annual Meeting, The Medical Society of New Jersey, Atlantic City, May 19, 1968. This work is from the New Jersey State Hospital at Ancora (Hammonton), of which Dr. Brunt is Medical Director.

in crisis; from alert school teachers recognizing warning signals of distress in their young pupils; and from closely observant clergymen picking up signs of disquieting despondency in their parishioners.

I felt that it was only logical and appropriate, of course, that such requests should come to the area's 1900-bed psychiatric facility and, resultingly, I decided to study more closely the possible anti-suicide role that a State hospital—geographically located in a remote area—could provide to the many communities of South Jersey.

Knowing suicide to be one of the first ten causes of death in the United States—with some 20,000 suicides recorded annually—and to be among the first five in the younger age groups, I recognized it, of course, as a serious public and mental health problem.

This recognition was made more indelible with the realization that, although 70 or so American people are reported as taking their own lives daily, studies indicated the true number to be considerably higher. Reports revealed that, because of the stigma associated with suicide, many self-inflicted deaths were not recorded as such. Further concern was inevitably forthcoming, too, upon learning that statistical averages indicated that *every minute an American citizen attempted to kill himself.*

In next delving into suicide information relating to New Jersey, I found the latest statistics then (as released by the New Jersey Department of Health) to reveal that in 1964 there were 517 suicides in our State, reflecting a rate of 7.8 per 100,000 population. The figures further indicated, however, the higher rate of 9.1 per 100,000 population for Ancora's seven-county catchment area, where there was a total of 114 suicides in 1964. Of these, 33 were females. Highly significant in the incidence of suicide in this southern tier of counties was a 56 per cent increase since 1958, when the seven-county total was 73.

As the result of extended discussions with the hospital staff concerning the seriousness of the suicide problem and the possible ways that the hospital could help to diminish the problem, Ancora State Hospital directed its attention to the organization of a hospital-based, anti-suicide program to serve the community. Particularly motivating Ancora's establishment of a suicide center was the realization that the hospital's catchment area had a higher suicide rate than New Jersey as a whole.

Within the confines of a limited budgetary allowance for its goal of effecting an anti-suicide program, Ancora directed its efforts toward a Suicide Prevention Telephone Service. Staff discussions revolved around the minimal requirements to launch such a project—the mechanics of phone calls, the basic psychologic principles of telelphone interview, a meaningful questionnaire, the selection of participating hospital staff, as well as the utilization of appropriate resources in the community.

Operational on February 3, 1966, the Ancora Suicide Prevention Telephone Service was established to function on an around-the-clock basis, including nights, week-ends, and holidays. As originally planned, calls coming in on the special telephone line, with the advertised and easily remembered number 561-1234, are immediately directed to a senior psychiatrist on the hospital staff. These eight, selected staff members serve on a daily rotating basis and each has a special telephone installation in his home on the hospital grounds, thus assuring coverage at all times.

Preparation of the medical staff for their participation in this new emergency service was reflected in their more intensified study of the problem of depression and suicide through frequently scheduled seminars, films, lectures by authorities in the field, as well as through augmented review of pertinent literature.

Preparatory ground work was carried out, in addition, for appropriate professional

groups and agencies in the community. Surveys, rosters, meetings—these were facets of the continuing program of acquainting and enlisting the cooperation of community-based groups, such as physicians, psychologists, social workers, clergymen, out-patient clinics, mental health organizations, and various health and welfare agencies.

Extremely helpful and cooperative have been the various public information media which, from the beginning, gave enthusiastic support to an appropriate coverage of program details. Much of this continuing interest of the press has undoubtedly been the result of the highly emotional aspect and human interest value of news concerning an organized suicide prevention program serving the interests of its reading public.

Unique as a state hospital with a Suicide Prevention Telephone Service manned solely by staff psychiatrists, Ancora reflects this medical orientation in the questionnaire filled out by the therapist for each incoming call, whenever possible.

In outline form, the questionnaire provides for the caller's name and/or case number; date and time of call; and the name of the physician. Also called for is such situational data as address; telephone number; weapons available; whereabouts of nearest friend, relative, or physician; preparations made for suicide; and precipitating circumstances.

Sought as descriptive data are threats (suicidal or homicidal); possibility of drunkenness; statements made; physical complaints and status; and mental and emotional status. Requested as historical data are previous suicidal attempts; use of drugs or alcohol; hospitalization or previous breakdown; and length of time in self-destructive mood. Also included is an outline for personal data, including age; sex; religion; color (by inference); marital status; family history of mental illness; occupation; and financial status.

The questionnaire's conclusive phase allows for indicated comments on appointment made; referral; police or others notified; attitude of caller upon termination of call; and length of interview. Also provided for are diagnostic impressions under which are listed diagnosis, prognosis and degrees of risk (high, moderate, low). Used wherever possible is the space provided for post-contact data.

The fairly comprehensive and searching nature of the questionnaire has made it possible for Ancora to extract much pertinent data throughout the operation of its Suicide Prevention Telephone Service in 1966 and 1967. In 1966 there were 160 calls registered; and in 1967, we had 169 calls. The statistics interestingly also reflect approximately equal numbers and percentages in each of the categories listed in the questionnaire. It will suffice, therefore, for me to give you only the 1967 figures.

Male callers totalled 43; female callers numbered 126. This is a one-to-three ratio. Of callers identified as to color, 94 per cent were white. The marital status of 123 callers was determined, including 71 married (58 per cent), 22 single (18 per cent), and 30 separated, divorced, or widowed (24 per cent). The religion was elicited in only 31 cases—12 being Roman Catholic (38 per cent), 17 Protestant (54 per cent), and 2 Jewish (6 per cent). The age brackets of 109 callers were: 5 under 20 years (4 per cent); 39 in 20 to 29 group (36 per cent); 31 in 30 to 39 (28 per cent); 28 in 40 to 49 (26 per cent); and 6 in 50 years and over (5 per cent). Of the 169 callers there were 43 previously hospitalized (26 per cent) and 42 had previous mental illness. Previous suicide attempts were admitted by 31 (18 per cent). Homicide threats were made in 14 of the 169 calls.

The types of calls were determined in 139 cases and included 50 suicide (36 per cent); 69 crisis (50 per cent); 6 homicide (4 per cent); 7 informational (7 per cent); 1 accidental poisoning; 4 prank calls; and 2 unknown. Ascertained in 32 cases were the weapons available at the time of the call. There were 22 with drugs (68 per cent); 3

sharp instruments (9.3 per cent); 2 fire arms (6.2 per cent); and one each of flammable liquids, rope, car, plastic bag, and gas.

The time of call was logged in 159 cases. There were 31 between midnight and 4 A.M.; 11 from 4 to 8 A.M.; 25 from 8 A.M. to noon; 24 from noon to 4 P.M.; 29 from 4 to 8 P.M.; and 39 from 8 P.M. to midnight.

Insofar as financial status is concerned there was a determination made in 58 cases— comfortable finances in 7 cases (12 per cent), average in 32 cases (55 per cent) and a below average in 19 cases (33 per cent).

With diagnostic impressions recorded on 153 of the callers, they included 18 psychotic (11.7 per cent); 79 non-psychotic (51.6 per cent); 56 under the influence of alcohol (37 per cent), but none considered intoxicated. Evaluation of the degree of risk in 98 cases reflected 20 high risk, 39 moderate, and 39 low (40 per cent)

Of the 169 calls, help was dispatched to 21 callers (12 per cent). Limited post-contact data revealed that lives were actually saved in six cases, representing 3½ per cent of the total calls during 1967. Of the 169 calls, 76 were classified as anonymous. Average duration of interview per call was 30 minutes. Of the 169 recorded calls during 1967 there were 17 callers admitted to Ancora as patients.

Among the precipitating factors involved in the year's calls, in the order of frequency, were marital problems; influence of alcohol; love problems; physical illness; loneliness and isolation; problems with children; problems with parents; post-partum depression; and failure in school.

In the opening phases of the telephone consultation, the initiative is entirely in the capricious hands of the caller. He often terminates the contact abruptly in response to undifferentiated or unspecified reactions. If the interview progresses, (usually in 25 to 30 minutes) the initiative changes sides and the caller is firmly "engaged." In this phase, we usually concentrate on our referral role which is an integral part of the service. Even though a typical "consumer" rejects further contacts, it is reassuring for him to learn that there are "others" who care, that indeed there is a whole system of "others," a benevolent conspiracy, so to speak, to help him, if he decides to seek help.

Contrary to occasionally reported findings concerning the effectiveness of organized suicide centers and though the history of Ancora's program is but a brief two years, our Suicide Prevention Telephone Service has already demonstrated its value through achieving the primary purpose for which it was established—that of providing to the troubled person in the community an immediately available instrument of direct help. Its value has proved to be more than only an effective tool of psychiatric first aid, however; it has also served as a surprisingly fine catalyst in bringing the hospital and the community together. The appreciative citizenry recognizes the emergency program as a concrete example of how Ancora strives to go beyond its obligations as a State hospital in its constant endeavor to provide as comprehensive a service as possible in the field of mental health. This spreading public awareness and appreciation of Ancora's anti-suicidal role has led to the community's increased proprietary interest in the hospital and resultingly greater understanding of the problems of the mentally ill.

To many in the community the telephone in the home has already become a symbol of Ancora's willingness to extend a helping hand when needed. Hopefully this feeling will grow among the area populace—for what greater acceptance can a public mental hospital expect than to have in the home a symbol of that hospital's readiness to respond to a "cry for help."

Ancora State Hospital

Think you can tell a man from a woman? Read this . . . and think again.

Testicular Feminization Syndrome*

Report of a Case With Chromosome Studies

Cheh-San Shih, M.D., Marvin Shuster, M.D. and Donald Kline, M.D./Perth Amboy

Testicular feminization is an hereditary disorder characterized by female habitus, male gonads and male karyotype.

Amenorrhea, infertility and congenital "hernia" bring these patients to medical attention. The syndrome is infrequent and requires cytogenetic testing and/or biopsy for confirmation. Diagnosis in childhood is important. The following case prompts this paper:

The patient is an 8 month old "female" infant admitted to Perth Amboy General Hospital with right lower lobe pneumonia. She had had fever and cough during the five day period preceding her hospitalization. Knowledge of the patient's past history is limited since the information was obtained from a foster parent. The child weighed 4 pounds 8 ounces at birth and was noticed to be jaundiced in the early postnatal period. No cause for this was documented but she received a blood transfusion. At 6 months she underwent surgery for an incarcerated left inguinal hernia at which time a round mass found to be a testis (Figure 2) was noted at the operative site and removed.

The child was a well developed, well nourished, active "female" infant who appeared to be having no respiratory distress. Examination of the skull revealed no abnormalities. A non-purulent conjunctivitis was noted bilaterally; the tympanic membranes were hazy; there was no significant adenopathy. Auscultation of the chest revealed harsh breath sounds and occasional rales in the right lower lung fields posteriorly. There was no hepatosplenomegaly. External genitalia were female. The labia appeared normal, the mons pubis was somewhat prominent and the clitoris was well developed. (Figure 1) There was a healed surgical scar in the left inguinal region.

The child's pneumonia responded to penicillin. Because of this history of testicular tissue removed a few months prior to this admission and the female habitus,



Figure 1.

External genitalia of an 8 month infant who turned out to be a "male."

chromosomal analysis was undertaken. Peripheral blood was cultured and buccal smears were evaluated. The buccal smears were chromatin negative. The modal number of chromosomes was 46 and karyotype demonstrated normal chromosomes with an XY sex chromosome complement. (Figure 3)

The term testicular feminization was suggested in 1953 by Morris[1] and was widely accepted. These patients contribute to the category of male pseudohermaphroditism. They have no uterus, cervix, or fallopian tubes. The vagina is usually short with a

*The work is from the Institute of Laboratory Medicine and the Pediatric Department of the Perth Amboy General Hospital. Dr. Shih is resident in pathology and Dr. Shuster is an Associate Pathologist at that hospital. Dr. Kline is an Assistant Attending Pediatrician there.

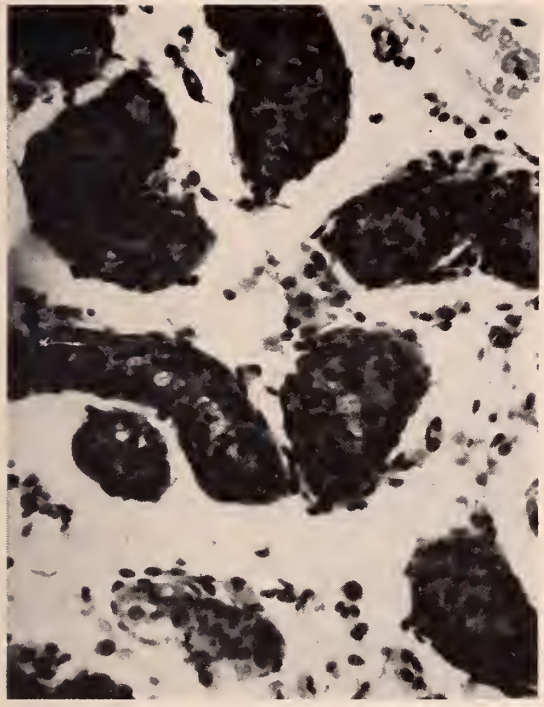


Figure 2.

High powered view of the testis showing seminiferous tubules. (H & E stain)

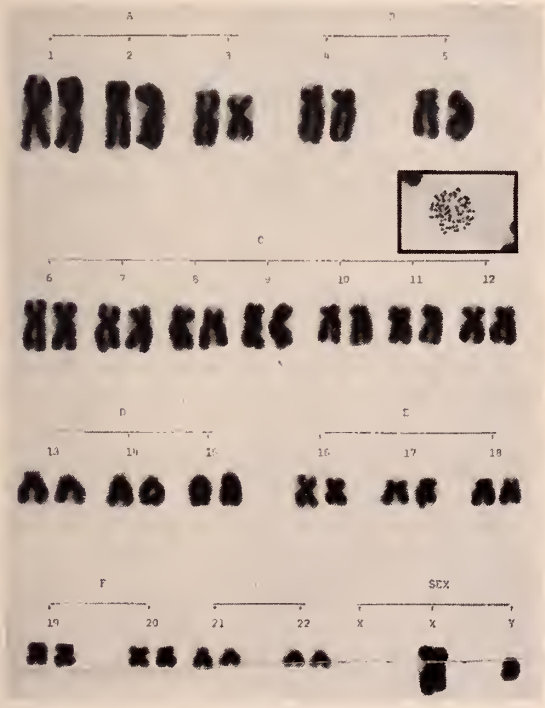


Figure 3.

The normal male karyotype of the patient whose external genitalia are shown in Figure 1.

blind end or may be completely absent and the clitoris is normal or enlarged.[2] There is absence of pubic and axillary hair. The gonads are immature testes which are intra-abdominal along the course of the inguinal canal or in the labia majora. Microscopically these testes show tubules lined by primitive germ cells and some Sertoli cells. Spermatogenesis is rare. The Leydig cells may be absent[3] or grouped into adenomatous formation.[3,4] There may be areas of ovarian-like stroma which are not found in undescended testes. Hormonal studies show these gonads are the most important source of the patients' estrogen.[5] Cytogenetic investigation reveals chromatin negative epithelial cells and the chromosomes are normal in morphology and modal number with an XY sex complement.

A pseudohermaphrodite is an individual with the gonads of one sex, and the genital ducts or external gentilia, or both, which are ambiguous or of the opposite sex. They are termed male or female on the basis of the gonads present. True hermaphroditism is a rare entity characterized by the presence of both testicular and ovarian tissue, either as separate gonads,[1] or combined as an ovotestis.[1,6] There have been no cases on record where self-fertilization has occurred although in some ovum and sperm production has been noted. These latter individuals may have chromatin positive or chromatin negative epithelial cells.

There is strong evidence that the etiology of this syndrome is an hereditary endocrine abnormality, essentially related to a lack of androgen effect.[3] Abnormal embryonic development and abnormal secondary sex characteristics are the result. Normally, during the fourth week of gestation, indifferent gonads appear in embryos of both sexes. In the male the medulla of this structure evolves into a testis, and the cortex largely regresses. In the female, the cortex differentiates into an ovary and the medullary portion disappears. An inducer or organizer substance is produced by a functioning testis to inhibit the development of the Mullerian ducts and to stimulate that of the Wolffian ducts in the

presence of androgen.[7] In testicular feminization, deficient androgen in the male fetus results in failure of development of Mullerian and Wolffian ducts and the external genital differentiation follows female lines. It was inferred that, somewhere on the X-chromosome, there is a sequence of genes involved in control of testicular androgen function. These genes are turned "on" as a unit to function possibly due to the influence of the Y-chromosome. They are silent or stable in the female genotype. An X-linked recessive trait has been documented.[3,5,7,8]

The gonads in this syndrome produce androgens and estrogen of significant biological activity.[2,3,4] The former is produced in amounts equivalent to that in the fetal testis. The latter results in development of the breast and female body habitus. There are reasons to believe that these hormones are produced by the Leydig cells. Urinary excretion of estrogens, 17-ketosteroids and pituitary gonadotrophins in these patients is high or at the upper range of normal for males.

Cytogenetic studies to be carried out include sex chromatin determination on buccal smears and leukocyte cultures of peripheral blood for karyotyping. The buccal smears usually reveal no nuclear chromatin masses (Barr Bodies). It is suggested that this test be performed after 4 days of age to avoid false negative results.[9] The chromosome complement usually shows basic diploid count of 46 with 22 pairs of autosomes and an XY sex chromosome complement. Triple mosaicisms of XO/XY/XX and XY/XYY/XXY have also been reported in individual case studies.[3,4]

More than 50 per cent of these patients have had inguinal hernias with the gonads in the inguinal region or in the labia majora. Since neoplastic changes of these undescended gonads are known to occur, surgical removal after puberty is definitely indicated. Estrogen substitution therapy may be of benefit.

This syndrome may pose interesting and difficult legal, social, moral, and religious problems. It also raises the question of what constitutes male or female. Should we be guided by genetic sex in establishing an individual's role in society or is morphologic characterization a more apt basis for this determination?

Certainly the clinical situation must be taken into account. If the patient presents as an adult, either for sterility or menstrual problem, the course of action differs from that when the patient is first seen as an infant. In the case of a married person with testicular feminization syndrome, we feel strongly that no mention be made of the fact that the genetic sex differs from the phenotype. To do otherwise would be destructive for the personalities involved and for the marriage. One would do better to indicate that the amenorrhea and sterility was of an unusual type with no hope for reversal. The moral and religious aspect of a marriage situation is the convention of male marrying female. Here, unfortunately, a phenotypic female but genetic male sometime marries a normal male. The problem may be complicated, but is fortunately rare. Many cases of individuals with testicular feminization carrying out a normal female role in marriage are documented and the authors see nothing to be gained by informing these patients of the true situation.

When the syndrome is discovered in an infant or child, our advice is to say nothing to the parents regarding the fact that the child is a male. Morphologically these individuals grow to have the body of a mature female except that they lack axillary and pubic hair, and are amenorrheic and sterile. The parents should be told that the child would not have normal menses and that "she" would be sterile.

Summary

A case of testicular feminization with chromatin negative epithelial cells and normal male karyotype is reported. Screening tests of sex chromatin by buccal smear and chromosomal studies are indicated in all patients

with congenital inguinal hernia, primary amenorrhea, and infertility.

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Your Body And How It Works

Parents' difficulties in talking to their children about the human body are now overcome with the assistance of the American Medical Association's new book, *Your Body and How It Works.* It is written in the language of a child in the early elementary years. The book is for the parent and child to read together. It fosters the attitude that the body is a beautiful gift and encourages an interest in taking care of it.

The colorful, 30-page book mentions the functions of the exterior parts of the body, along with describing and illustrating the internal systems, such as the heart and circulatory, nervous, respiratory, and digestive. The section on the respiratory system describes how the air comes into the body and traces the route of air through the system until it leaves the body. Illustrations of the heart and circulatory system show the mass of blood vessels in the human machine.

The book ends with hints for helping the body keep strong and well. There is an excellent drawng of the four basic food groups with a reminder for children to eat some of the food from each group every day. Other hints encourage outdoor activities, rest and sleep, regular brushing of teeth, washing hands before eating and after going to the bathroom, and having regular physical checkups. The text is written in a similar style and uniquely illustrated by the same artist who illustrated "Your Friend the Doctor," an AMA educational book used for preparing children for visits to the physician.

Both books are available from the AMA's Order Handling Department. Prices for *Your Body and How It Works* are: single copies, 45 cents each; 50 to 99 copies at 43 cents each; 100 to 499 copies at 41 cents each: *Your Friend the Doctor* is available at 40 cents each; less for quantities of 50 or more.

The potentialities of caval plication are here reviewed.

Caval Plication As An Adjunct To The Management Of Pulmonary Embolism*

E. Bruce Hallett, M.D./Morristown

The catastrophy of massive pulmonary embolism is feared by all physicians. Its dramatic onset and development dictate the need for prompt and aggressive management. Improvement in the care of thromboembolism appears associated with increased diagnostic suspicion, and the utilization of currently available methods. Modification of the natural history of this process involves, on occasion, a direct surgical attack upon the inferior vena cava and the iliofemoral venous system.

Classification of Thrombophlebitis

Virchow[12] described the factors relating to the development of venous thrombosis as those of trauma, stasis, and hypercoagulation. He recognized that a frequent source of fatal pulmonary emboli was the veins of the legs. Today, the spectrum of individual responses to venous thrombosis is arbitrarily divided into thrombophlebitis and phlebothrombosis. Although these are undoubtedly reactions to the same insult, they represent clinically dissimilar manifestations of venous thrombosis. The intense interstitial inflammatory reaction seen in thrombophlebitis leads to relatively secure intraluminal clot adherence, and thus a more limited potential for embolism. Phlebothrombosis, on the contrary, provides a lesser degree of inflammatory infiltration and a reduced potential for clot adherence. However, the eventual organization which occurs in both instances is similar, with the destructive production of the postphlebitic extremity. Venous thrombosis may be classified pathologically in this fashion, recognizing that the basic inceptive processes are probably identical.

There may be quantitative as well as qualitative differences in thrombophlebitis. This is particularly helpful in outlining management protocols. Haller[1] has classified clinical thrombophlebitis into four basic groups. These include localized superficial thrombophlebitis, localized deep thrombophlebitis (calf veins), extensive deep thrombophlebitis (phlegmasia alba dolens), and massive deep thrombophlebitis (phlegmasia cerulea dolens). Discussion will be limited to problems with major embolic potential, thus eliminating at least superficial phlebitis.

Changes Secondary To Venous Thrombosis

Major physiologic changes are seen when extensive and massive venous occlusion is encountered. Extensive fluid shifts in the involved extremities occur, triggering constitutional reactions of considerable magnitude. The massive edema seen is associated with clinically significant extracellular fluid sequestration. According to Brockman and Vasko[2], this may represent as much as 50

* Read before the Sections on Radiology and Surgery, Annual Meeting, The Medical Society of New Jersey, Atlantic City, May 20, 1968.

per cent of the plasma volume. The sequential hypovolemia is manifest by an increasing hematocrit, a decrease in central filling of the venous system, hypotension, decreased cardiac output, and impaired renal perfusion. Secondary oliguria and renal shutdown may follow. In the presence of a pulmonary embolus, cardiac output decreases further due to increased pulmonary resistance, increased right ventricular pressure, and decreased oxygenation. Evidence of myocardial insufficiency and cerebral anoxia may compound the problem.

The extensive fluid sequestration in the extremity appears related to both venous and lymphatic obstruction. In 1929, Homans and Zollinger[3] were unable to induce edema in the extremities of dogs with venous ligation alone. They suggested the possibility of lymphatic involvement. More recently, Haller and Mays[4] ligated the entire iliofemoral system in dogs without the production of edema. However, with the addition of venous thrombosis, edema appeared. The inflammatory response to thrombosis was implicated as an inciting factor in the development of lymphatic obstruction.

Major venous pressure changes are in evidence and accompany venous thrombosis. Edwards[5] recorded saphenous venous pressure in patients exhibiting massive venous occlusion, and found this to be as high as 995 centimeters of water. Changes in the venous pressure in dogs has been measured by Anderson and Shields[6], and their figures reflect similar changes. When the venous hypertension increases above the colloid osmotic pressure, fluid passes to the interstitial space. With the development of arterial hypotension, and a decreased hydrostatic pressure, some reduction in this trend occurs.

The picture presented sets the stage for the dramatic and feared complication of embolism. The acutely ill patient is hardly in a position to withstand this further insult. At this time it is opportune to point out that relatively few patients demonstrate this fulminating complex. Often, the pelvic veins are primarily involved as a source of thromboembolism, thus reducing markedly this massive constitutional response. In such instances, the physiologic consequence of the embolism itself determines the immediate outcome.

Diagnosis

The diagnosis of pulmonary embolism has many pitfalls. According to DeBakey[7] the diagnostic error exceeds 50 per cent. Gorham[8] also reports a sizable diagnostic error. The problem is most likely to be difficult in circumstances where the focus of phlebitis is not apparent. This concept deserves emphasis. Myocardial infarction represents the single largest diagnostic problem, having been incorrectly diagnosed in 20 per cent of Gorham's series[8]. Congestive heart failure and angina pectoris are other cardiac diagnoses which may simulate embolism. Pneumonia, aletectasis, peptic ulcer, hiatal hernia, and strokes have also been entertained as primary diagnoses. The following case report illustrates the diagnostic difficulties.

A 70 year old female was admitted May 9, 1967 following a fall in which she sustained a fracture of the right knee. Her general health had been good except for hypertension. Medical evaluation revealed electrocardiographic changes compatible with an old inferior wall infarction, and left ventricular hypertrophy. Examination demonstrated some cardiomegally, and this was confirmed by x-ray. No murmurs were heard.

Table 1

Differential Diagnosis of Pulmonary Embolism

1. Myocardial Infarction
2. Pneumonia
3. Atelectasis
4. Congestive Heart Failure
5. Angina Pectoris
6. Peptic Ulcer
7. Hiatus Hernia
8. Cerebral Vascular Accident

Table 2

Symptoms of Pulmonary Embolism

1. Occlusion of Lobar Branch of Pulmonary Artery
   - a. Dyspnea
   - b. Palpitation
   - c. Pleural Pain
   - d. Bloody Sputum
   - e. Cough
   - f. Pleural Rub, Rales

2. Occlusion of Major Pulmonary Artery
   - a. Acute Cor Pulmonale
   - b. Venous Engorgement
   - c. Syncope
   - d. Precordial Pain
   - e. Cough
   - f. Dyspnea
   - g. Arrhythmia
   - h. Nausea
   - i. Shock
   - j. Weakness

The patient was placed in a long leg cast, and started on physiotherapy. She was digitalized. Progress was satisfactory until the 13th day when she developed dyspnea, chest pain, and fever. X-ray revealed a pleural effusion. Antibiotics were prescribed with the thought that the process was pneumonic. Four days later, a similar episode occurred. A repeated chest film demonstrated persistence of the pleural effusion. A radioisotope lung scan showed a "cold" area in the left lower lung field, thought to represent a pulmonary embolus. Despite the administration of heparin, a third episode occurred on June 7. At this time, a caval plication was performed via the extraperitoneal approach. The operative procedure was uneventful. Forty-eight hours later, she again developed dyspnea, chest pain, and tachycardia. This responded well to analgesics and oxygen. Progress appeared satisfactory until July 2 (two months after admission) when a final attack occurred. She became unresponsive and quickly expired. Post mortem examination failed to show any evidence of pulmonary emboli. The cause of death was assigned to acute pulmonary edema. Interestingly, at no time did this patient exhibit any evidence of thrombophlebitis.

The symptom complex initiated by the pulmonary embolus appears to be a function of size and location. Small emboli occluding lobular or sublobular branches are associated with dyspnea, cough, pleural pain, and palpitation. Occasionally, bloody sputum is observed. Physical findings include decreased breath sounds and a pleural friction rub. In larger emboli, occluding major pulmonary branches, more profound constitutional changes occur. These include acute *cor pulmonale* with increased pulmonary resistance, and an increased right ventricular pressure. Shock and cyanosis appear, and dyspnea is profound. In all such cases, clinically apparent phlebitis is present in fewer than 20 per cent of cases.

Fortunately, the diagnostic tools have improved, and if the patient survives the initial insult, confirmatory technics may establish a firm diagnosis. Chest x-rays are rarely helpful in a positive sense, but may aid in avoiding an erroneous diagnosis. Cardiograms and enzyme studies may be augmented by radioisotopic scans and pulmonary arteriography. The latter appears most useful. It can be performed quickly where time is a prime factor, and is mandatory prior to pulmonary embolectomy.

Indications For Caval Plication (Or Ligation)

Most physicians treat thrombophlebitis with anticoagulants; the use of adjunctive measures, however, is increasing. The classical approach utilizes bed rest, extremity elevation and support, plus heparin. The continued endorsement of this protocol is based on its success. In instances where an initial embolus has occured, Arylan[9] reports that of those properly anticoagulated, only 10 per cent have a second embolus. However, the inexorable consequences of extremity venous obstruction remain. In this area, venous thrombectomy appears helpful. In instances where the phlebitic process extends into the common iliac or caval systems, a concomitant plication procedure appears indicated. Clot fragmentation is the principle hazard where the physical bulk of the caval thrombus may not accommodate to the reduced size of the femoral vein. Isolated episodes of embolism have been observed without this protection. In instances where residual clot remains after thrombectomy, perhaps a more compelling reason for plication exists. In massive venous thrombosis where caval involvement is the rule, cavotomy with thrombectomy is necessary, and is accompanied by partial venous interruption. The following case report is illustrative:

Table 3

Indications for Caval Plication (or Ligation)

1. Repeat Embolus While Receiving Anticoagulants
2. Massive Caval Thrombosis (Phlegmasia Cerulea Dolens)
3. Chronic Cor Pulmonale due to Recurrent Embolism
4. Active Bleeding Potential
5. Septic Thrombophlebitis (Ligation)
6. Following Pulmonary Embolectomy
7. In Association with Thrombectomy (Residual Clot)

A 28 year old dairy manager was admitted Dec. 17, 1965 complaining of marked swelling and bluish discoloration of the right leg from toes to groin. He had been well until one week prior to admission when he experienced pain in the right groin and lower abdomen. Pain was increased with activity, but there was no change in skin color nor any marked swelling of the leg. The patient dismissed this complaint until the morning of admission when he awoke with marked swelling of the entire leg associated with bluish discoloration and increased pain. He was unable to walk without marked discomfort. There was no history of trauma, although he had been on a hunting expedition the day preceding hospitalization. There was no history of recent surgery or illness. The patient had not been on medication of any type.

His temperature on admission was 101. He appeared well nourished. Skin was pale and cool. The right leg was edematous, being three times normal size with purpuric spots over the extremity. The skin was bluish, cool and tense. A femoral pulse was felt, but no pulses

in the distal portion of the leg were noted. Tenderness in the right lower abdomen was also present.

The clinical impression was that of massive iliofemoral thrombophlebitis. It was felt that some form of decompressive surgery was urgently required. After suitable preparation, he was taken to the operating room where a caval plication and thrombectomy were done. A large thrombus was removed. However, total venous clearance was thought to be incomplete, so a supplementary fasciotomy was performed. Postoperatively, he was maintained on heparin therapy which was gradually withdrawn, as the patient was transferred to oral anticoagulants. At no time was there any suggestion of embolism. Recovery was uneventful. Followup demonstrated some mild residual edema of the right leg.

The management of septic phlebitis includes vena caval ligation along with interruption of the ovarian veins. Ligation is required to block small septic emboli which may pass through the caval screen usually produced with plication. The problem is seen most often in septic abortions, suppurative genital and prostatic disease. Fortunately it is rare. In certain instances, anticoagulant therapy is contraindicated due to high bleeding potential. Neurosurgical and urologic cases fall into this group, along with certain ulcerative gastrointestinal disorders. Chronic *cor pulmonale,* as a consequence of repeated pulmonary emboli, demands caval plication to arrest the progresson of the disease. This process is well demonstrated on pulmonary arteriography. In addition, either ligation or plication appears to be a necessary adjunct in patients undergoing pulmonary embolectomy.

Surgical Approach

In most instances, satisfactory exposure of the infrarenal cava can be obtained by a retropertoneal procedure. This produces a minimal disturbance of intraperitoneal visceral function, but lacks exposure of the ovarian vessels, should their interruption appear desirable. In addition, for those patients receiving anticoagulant therapy, the large retroperitoneal area presents a bleeding potential which is somewhat greater than that of the transperitoneal approach. Where either caval or ovarian venous involvement is suspected, the transperitoneal avenue is distinctly preferable. The absence of caval opacification on venography aids in the confirmation of caval thrombosis, and in this way may influence the surgical approach. In any case, operative containment can be readily obtained by one of these approaches.

Postoperatively, elevation, leg support, and anticoagulants are recommended, along with the usual programs to allay pain, maintain good ventilatory exchange, and prevent infection. Anticoagulants are prescribed for a minimum period of three months, heparin being used for the initial 10 to 14 days, followed by a suitable oral preparation. Sturdy leg support is essential, along with significant leg elevation in the early postoperative period. Ambulation is encouraged, beginning on the second or third postoperative day, provided the patient's general condition permits. No sitting is permitted. Subsequently, leg support is maintained for 3 to 6 months, or longer if residual edema persists. Moderate sodium restriction and diuretics are usually helpful. Special hygienic skin care is recommended.

Table 4

Sequellae of Caval Interruption

1. Edema
2. Chronic Recurrent Phlebitis
3. Proximal Thrombosis
4. Decreased Venous Return (Temporary)
5. Varicose Veins
6. Stasis Dermatitis
7. Pain
8. Ulceration

Hazards of Caval Interruption

Laceration of lumbar veins with hemorrhage, postoperative caval thrombosis, and systemic hypovolemia may appear as immediate problems in caval interruption. Significant temporary reduction in venous return has been reported by Mortez[10] and associates. Occasional fatalities, particularly in cardiacs, may be related to this phenomenon.

Postligation swelling of both lower extremities was reported by Dale[11] in 10 to 20 per cent of the cases. Unilateral edema is more common, occurring in up to 75 per cent of those treated with caval ligation. It is re-

Table 5

Results of Caval Plication or Ligation
Morristown Memorial Hospital 1962-1967

Sex	Age	Indication	Site of Phlebitis	Caval Involvement	Thrombectomy	Residual Edema
M	47	Embolism Heparin Failure	Unknown	0	0	1+ Bilateral
M	28	Phlegmasia Cerulea Dolens	Rt. Leg	+	+	2+ Rt. Leg
F	70	Embolism Heparin Failure	Unknown	0	0	0
F	24	Phlegmasia Cerulea Dolens	L. Leg	+	+	1+ L. Leg
M	57	Phlegmasia Alba Dolens	L. Leg	0	+	0
M	62	Phlegmasia Alba Dolens	Rt. Leg	0	+	0
F	39	Embolism Heparin Failure	Unknown	0	0	0
M	54	Phlegmasia Alba Dolens	Rt. Leg	0	+	1+ Rt. Leg

cognized that edema is related to the extent of venous thrombosis and lymphatic obstruction, and not to the ligation itself. The addition of thrombectomy may appreciably reduce the incidence of dependent edema, provided that retrocaval patency persists. It is logical to conclude that caval patency will be favored where partial interruption is performed as opposed to total ligation where the likelihood of secondary thrombosis is high.

If residual clot is present, postphlebitic sequellae may develop. Secondary varicose veins, edema, stasis dermatitis, and ulceration represent the aftermath of venous insufficiency. The modification of this process is illustrated in Table 5. One half of this group of patients were totally free of residual edema, and in only one instance was bilateral edema present. In this case, thrombectomy was omitted. Five of the remaining cases were managed with thrombectomy, with serious residual edema a problem in but one instance.

Summary

The spectrum of venous thrombosis and embolism has been briefly reviewed. The physiologic changes, diagnostic methods, indications and sequellae of surgery have been discussed. The initial and limited benefits of superficial femoral vein ligation have been extended to include vena caval interruption. Embolic containment appears reliable. Adjunctive venous thrombectomy reduces the threat of postphlebitic problems, and is encouraged as a major therapeutic tool in the management of extensive or massive thrombophlebitis.

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60 Franklin Street

Weakness of external ocular muscles may occur in diabetics—myopathy and neuropathy are obvious causes. But don't forget myasthenia.

Cranial Neuropathy In Diabetes Mellitus*

A Problem in Differential Diagnosis

Elliott S. Wolfe, M.D./Jersey City
and
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Different anatomic segments of the nervous system may function abnormally in the patient with diabetes mellitus. The neuropathies that occur may be confused with other neurologic or muscular disorders. Diagnosis becomes particularly difficult when one suspects a motor neuropathy; it is then essential to distinguish neuropathy from myopathy. Furthermore, neuropathy may occur simultaneously with the symptoms of diabetes[2] or may precede the appearance of symptoms and the recognition of altered carbohydrate metabolism.[1]

The following case reports will illustrate specific problems of determining the etiologic diagnosis of cranial neuropathy in two patients with diabetes mellitus. Important aids to the early recognition of the correct diagnosis will be emphasized.

Case One

A 68-year-old married female had been in good health until one week prior to admission when she felt a burning pain in the region of the left eye and the left frontal area. She then realized that she was unable to elevate the left upper eyelid. When she opened this eye manually she was aware of diplopia in certain directions of gaze. An ophthalmologist found an external ophthalmoplegia. She was admitted to the hospital following the discovery of glucosuria. She had not had polydipsia, polyuria, nor polyphagia. Although a reasonably good appetite was present, her weight had dropped from 160 to 142 pounds in six months. There had been no exposure to potential toxins and no history of excessive intake of alcohol. There were no known family members with diabetes mellitus.

She was alert, oriented, and cooperative. Temperature, pulse, blood pressure, and respiratory rate were normal. The head was normal with no audible cranial bruit. There was ptosis of the left eyelid and paresis of the left levator palpebrae superioris. Pupils were equal and reacted to light and accommodation. External ocular movements of the left eye were abnormal because of paresis of those muscles innervated by the third and fourth cranial nerves; there was inability to deviate the eye medially and limitation of elevation and depression. Ocular fundi were normal except for arteriosclerosis of the retinal arteries. External ocular movements of the right eye were normal. The remainder of the neurologic examination was normal. A diagnosis of diabetes mellitus was confirmed by fasting hyperglycemia; no acetonuria was present. Cerebrospinal fluid examination showed an elevation in the concentration of glucose, but not in the concentration of protein. X-rays of the skull were normal except for hyperostosis of the frontal bone. A neostigmine test for myasthenia gravis was negative.

After treatment with a 1500 calorie exchange diet and tolbutamide, the blood glucose decreased and glucosuria disappeared. Within six months ptosis was gone and the external ocular movements were normal.

Case Two

A thirty-nine year old woman had diabetes mellitus for nine years. She had been in satisfactory control until she experienced two episodes of hypoglycemia within a two week period. During one of these episodes blood glucose decreased to 28 milligrams per 100 cc. Two weeks following the second episode of hypoglycemia, ptosis of the right eyelid appeared; she also noted diplopia. She had a complete paralysis of the right levator palpebrae superioris and a definite paresis of the right superior rectus. No other muscle weakness was noted. Fasting blood glucose was 212 milligrams, and serum protein bound iodine was normal. It was thought that the patient had a diabetic cranial neuropathy, with partial involvement of the right third nerve. An attempt was made to achieve more strict control of hyperglycemia. Initially there was improvement in the function of the right levator; however,

*At the time this paper was written Dr. Wolfe was a Medical Officer in the United States Public Health Service and was assigned to the New Jersey State Department of Health. Dr. Wolfe is now with the New Jersey College of Medicine and Dentistry. Dr. Krosnick is the Program Coordinator, Diabetes and Metabolic Diseases Control Program, New Jersey State Department of Health, Trenton.

ptosis became bilateral within two months. Fasting hyperglycemia disappeared during this period.

Three months after ptosis first appeared, she experienced weakness of both lower limbs after housework. Rapid progression of muscle weakness of all limbs then occurred. Repetitive falling, inability to step into a bus, and the need for assistance when walking were chief complaints. The patient believed that muscle power was least during the latter part of the day. She began to have difficulty chewing and swallowing food.

She was an agitated patient with bilateral ptosis. Speech was slurred, and she was barely able to stand from a sitting position or to walk without assistance. There was pronounced paresis of all external ocular muscles and a fixed, forward gaze. The nasolabial folds were flattened. Weakness (without atrophy) of upper and lower limb muscle groups was moderately severe. Repetitive movement increased the weakness in the muscle being tested. The deep tendon reflexes were active and equal; the plantar responses were flexor. Sensation was completely normal.

Following the intravenous administration of 10 milligrams of edrophonium chloride (Tensilon)® muscle power increased, ptosis disappeared and the external ocular movements improved. The edrophonium chloride test confirmed the clinical impression of myasthenia gravis.

The patient was placed on oral neostigmine bromide. Symptoms of myasthenia lessened but were still severe. She was then started on pyridostigmine bromide (Mestinon).® Once again only a small improvement in muscle strength occurred. She died two months later in a myasthenic crisis which had been precipitated by a respiratory infection.

Comment

Each of these patients had diabetes mellitus and each had ptosis and external ophthalmoplegia. Although both were believed to have extrinsic eye muscle weakness because of diabetic neuropathy, one patient developed progressive generalized muscle weakness and the classical syndrome of myasthenia gravis.

The true prevalence of diabetic cranial neuropathy is unknown, but this complication is not rare. Ocular palsies were present in five out of one hundred patients with diabetes observed by Leopold,[5] and in one per cent of patients reported by Walsh,[11] and by Weinstein and Dolger.[12] Among 325 patients with myasthenia gravis observed by Osserman,[7] 136 had, at first, only ocular symptoms.[7] Ptosis and/or extrinsic eye muscle weakness remained the only symptoms of myasthenia in 50 patients.

External ophthalmoplegia caused by diabetes more frequently involves the abducens and oculomotor nerves,[2] and less frequently the trochlear nerve.[8] More than one nerve may be involved at one time. Although involvement is usually unilateral,[2] both eyes may be affected.[9] Patients with myasthenia gravis may have unilateral or bilateral ptosis; in the series reported by Osserman,[7] 76 had unilateral ptosis and 81 had bilateral ptosis at the inception of the illness. Diplopia was noted at the onset of myasthenia by 133 patients. Aird[10] remarks that asymmetric involvement of the external ocular muscles is usually seen in myasthenia gravis but complete external ophthalmoplegia may develop bilaterally. Although there may be abnormalities of the pupillary reflex in patients with diabetes (an Argyll-Robertson pupil may occur) these are rare in patients with myasthenia gravis.[11]

A neuropathy of the fifth, seventh, or eighth cranial nerves may occur in diabetes.[11] Patients may have trigemminal neuralgia, unexplained odontalgia, peripheral facial weakness, or diminished auditory acuity. In myasthenia gravis there may be weakness of the facial muscles, masseters, muscles of palate, pharynx and larynx, tongue, sternomastoid and trapezius.[10]

Diabetic ocular cranial neuropathy often has an abrupt onset heralded by unilateral burning pain, localized to the orbital, frontal, or temporal region, and by diplopia. Examination will reveal abnormalities appropriate to the muscles involved. The first patient illustrates the presentation of this neuropathy. Often there is poor control of diabetes at the time the patient is first seen. Cranial neuropathy may antedate the recognition of altered carbohydrate metabolism. Other forms of diabetic neuropathy may accompany cranial neuropathy: most common would be a peripheral sensory neuropathy of the lower limbs. The first principle of treatment, after an accurate diagnosis is made, is to improve control of hyperglycemia. There is often recovery without residua although the course may last for weeks or months.

The second patient illustrates the difficulties of differential diagnosis in the patient with

diabetes mellitus. Physicians will attempt to relate any new symptom or sign in the patient with diabetes to the known complications of this disease. This patient was initially thought to have weakness of the right levator palpebrae superioris and right superior rectus because of a diabetic ocular neuropathy. Fasting hyperglycemia at the time she was first examined (combined with the slight but definite improvement after institution of a more strict regimen) seemed to confirm this opinion. When profound symptoms of myasthenia gravis eventually appeared the diagnosis of diabetic neuropathy was no longer tenable.

Although it is true that "increasing fatigue with repetitive movement" and "recovery with rest" are characteristic of myasthenia gravis, diagnosis in an early stage may be difficult.[10] It has been stated that mild cases of myasthenia may not be detected at all.[7] Schwab[10] estimates that there are probably ten thousand unknown cases of myasthenia gravis in the United States. Remember that diabetes mellitus will coincidentally appear with other nosologic entities because of its high prevalence. As a pertinent example, there were eight cases of diabetes mellitus in Osserman's 375 patients with myasthenia gravis.[7] Parenteral anticholinesterase preparations[10] that have a rapid onset of action can be useful tools when problems of differential diagnosis arise.[7]

The second patient had severe myasthenia gravis and would be classified in Osserman's clinical group III: those patients with an "acute fulminating onset of generalized myasthenia with severe bulbar manifestations. Usually the respiratory system is involved early. In a short time from onset the patient may develop myasthenic crisis. These patients do not respond to drug treatment and have a very poor prognosis."[7]

Summary

Diabetes mellitus and myasthenia gravis are two specific causes, among many, of external ocular muscle weakness. When diabetes mellitus is not known to exist in a patient with ptosis or external ophthalmoplegia, a study of the patient's carbohydrate tolerance may reveal diabetes mellitus. Other causes for the paresis should be considered and investigated by appropriate procedures even if the patient has diabetes. Myopathies should not be ignored and myasthenia gravis should always be considered.

The problems of accurately defining the cause of an external ophthalmoplegia have been illustrated by two case reports. One patient developed external ocular motor weakness and had undiagnosed diabetes mellitus; a second patient had diabetes mellitus for nine years prior to the onset of myasthenia gravis. One must remain continually aware that other illnesses may occur coincidentally with diabetes mellitus.

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24 Baldwin Avenue

The two anomalies here described are almost unique; indeed, Case 1 is said to be the only one of its kind ever reported.

Congenital Anomalies Of The Gallbladder And Bile Ducts*

Report Of Two Cases

Victor D'Ambrosio, M.D./Murray Hill

Of the various anomalies of the gallbladder, the bilobate may have some importance with regard to the etiology of cholelithiasis and cholecystitis. These two conditions seem to occur only in one of the chambers of the bilobed gallbladder, but not in the other. (See Figure 1)

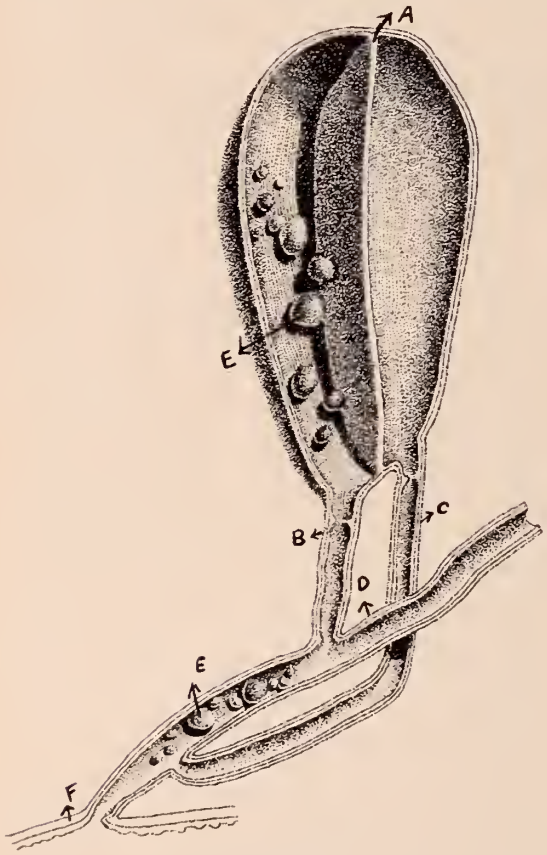


Figure 1.
(A) Septum separating two chambers. (B) Normal cystic duct. (C) Anomalous cystic duct. (D) Common bile duct. (E) Stones. (F) Duodenum.

The extra-hepatic biliary tract, along with its vascular supply, seems to have more anomalous structures than any other organ of the human body. Some 90 per cent of the strictures of the bile duct are caused by technical errors[6] made at the time cholecystectomy is done. The surgeon must be aware not only of all the *normal* variations of the structures of this area, but also of the anomalies that may occur among these structures, including:

(1) Double gallbladder and its variations.

(2) Diverticulum of the gallbladder and its various locations.

(3) Absence of the gallbladder.

(4) Different forms of the gallbladder—such as hourglass, phrygian cap, and rudimentary gallbladder with variations in the bile ducts.

Anomalies in the *position* of the gallbladder include:

(1) Intra-hepatic gallbladder.

(2) Gallbladder on the left side—on the undersurface of the left lobe of the liver.

(3) Retrodisplacement of the gallbladder. Gallbladders have been found along the vena cava, in the retroperitoneal space.

(4) Transverse position of the gallbladder, horizontally within the transverse fissure.

(5) Floating gallbladder.

*From the Department of Surgery, Overlook Hospital, Summit.

Bilobed Gallbladder

This anomaly is rare. Here the gallbladder is completely divided, and each cavity is drained by its own cystic duct.[4] Two forms of this anomaly are known:

(1) One has the appearance of a single gallbladder from the outside, but internally it is divided into two cavities by a longitudinal septum. (See Figure 1)

(2) The other type has the appearance of two separate gallbladders fused at the neck, as shown. (See Figure 2)



Figure 2.

Note the double chamber gallbladder and the respective cystic ducts draining each chamber separately.

Bilobed gallbladders have demonstrated that the metabolic malfunction is not likely to be the cause of stone formation. Stones have been found in one of the chambers, but not in the other. Gross's Review of World Literature[3] reported only two forms, the paired form and the one with normal external contour. Both of these drain by a single cystic duct into the common bile duct.

Bilobed gallbladder in man has been reported,[2] but no description of the form encountered in the case described below, has ever been published before.

Case 1

A 70-year-old man was transferred to the Veteran's Administration Hospital in Lyons, New Jersey, for elective gallbladder surgery on July 23, 1962. He had been in good health up to June 1962, when he began to experience bouts of epigastric pain and vomiting.

Within a short time, this was followed by clinical jaundice. Liver function tests showed increased total and direct serum bilirubin and increased alkaline phosphate 34 K.A.

X-ray revealed† a small pulsion esophageal diverticulum of mid-esophagus. The gallbladder series failed to visualize the gallbladder or extra biliary ducts.

At surgery, a thickened and somewhat contracted gallbladder containing multiple stones was found. The common bile duct was dilated, and contained multiple large stones. After long and somewhat difficult dissection two cystic ducts and one gallbladder were exposed as was the cystic artery, which was ligated. The two cystic ducts seemed to be draining into the same common bile duct. Having exposed the common bile duct, and with the left and the right hepatic ducts



Figure 3.

Note T-tube in the common bile duct and a long aberrant cystic duct, paralleling common duct. The other cystic duct, joining the common duct, has been ligated.

with the cystic artery already ligated, and with the two cystic ducts in clear view, ligation of these last two structures was carried out. After the common bile duct had been explored, the stones removed and the T-tube cholangiogram completed, we noticed that the anomalous cystic duct (draining the one of the two gallbladder chambers which contained *no* stones) was joining the true common bile duct at the ampulla of Vater. (See Figure 3)

† Renographin used in this study was furnished by E. R. Squibb and Sons.

The abdomen was then closed in layers with the Penrose drain placed in the Morrison's pouch and brought out with the T-tube through a separate stab wound. The patient made an uneventful recovery and has been asymptomatic ever since.

Further study of the area disclosed a single gallbladder with two chambers, each draining by a separate cystic duct. (See Figure 2) The chamber containing stones drained into the common bile duct at the usual location. The other chamber, containing no stones, was drained by a cystic duct, passing beyond the common hepatic duct and then running medial and parallel and joining the common bile duct just before the ampulla of Vater.

Rudimentary Gallbladder

The rudimentary gallbladder is a small nubbin or pouch at the end of the cystic duct. It can be found in infants and children. In those cases, it is believed to be due to congenital hypoplasia. Unless it is diseased, it requires no surgery.[6] In elderly persons, this could be the result of long standing infection secondary to cholecystitis. It may then require surgical removal.

This form of anomaly was found in our second case.

Case 2

A 72 year old man was admitted to Overlook Hospital with a diagnosis of "non-visualized gallbladder" suggesting stones. He had had several episodes of biliary colic during the previous ten years. All x-ray and laboratory findings were within normal limits.

At surgery, a right upper paramedian incision was made and the abdominal cavity was entered in layers. Exploration was negative except for adhesions in the right upper quadrant involving the subhepatic area and the hepato-duodenal ligament.

We were unable to identify the usual normal sized gallbladder. After careful dissection a small pouch, (about 15 by 20 millimeters) was found and seen coming off the common bile duct. It was apparent that this rudimentary gallbladder had been the site of repeated infections, manifested clinically as biliary colic. However no stones were found. The common bile duct and the hepatic ducts were of normal size. The small rudimentary gallbladder was excised, the abdomen was closed in layers with the Penrose drain placed in the Morrison's pouch and brought out through a separate stab wound. At the end of this procedure, a right inguinal herniorrhaphy was carried out successfully.

The patient made an uneventful recovery and has remained symptom free ever since.

The liver, gallbladder, and bile ducts develop from a bud-like projection in the ventral wall of the primitive foregut near its entrance into the yolk stalk. From this projection, or close to it, smaller ones may develop. These usually regress, but sometimes they do not. Then they can result[1] in the development of accessory gallbladders or ducts. The lumen of the gallbladder develops by a process known as vacuolization, which involves the formation of vacuoles simultaneously in different parts of the gallbladder. The lumen is the result of the fusion of the vacuoles. When this vacuolization fails to take place (or when splitting of the primary projection occurs) anomalies like strictures or congenital absence of the ducts or the gallbladder, or bilobed or double gallbladder may develop.

In general, extra-hepatic biliary ducts result from two or more buds giving off the primitive anlage. From the canalization of these extra buds accessory ducts may form. These buds usually disappear.[5]

Conclusions

Reported here are two cases of congenital anomalies of the biliary tract. A knowledge of the anomalies is important to anyone doing surgery in this area.

The bilobed gallbladder may throw some light on the mechanics of the formation of gallstones and on the reason why stones form in one chamber but not in the other.

Drainage of the bilobed gallbladder by two cystic ducts would assist the surgeon in his attempt to protect the common bile duct and in securing ligation of the two cystic ducts.

The rudimentary gallbladder is the cause of biliary colic in some patients. Its removal can restore the patient to a healthy and normal life.

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5. Lindner, H. H. and Green, R. D.: *Surgical Clinics of North America*. 44:1273 (December 1964)

6. Braash, J. W.: *Surgical Clinics of North America*. 38:627 (May 1958)

159 Southgate Road

Against the competition of the university hospital and the famous medical center, how can the community hospital meet its obligation as a center for medical education? Dr. Zangara suggests one way: affiliation.

Affiliations Of Community Hospitals And The Role Of The Regional Medical Program

Anthony J. Zangara, M.D.*/Morristown

The only hope for successful educational programs at the graduate level in community hospitals lies in affiliation with other institutions. This is particularly appropriate for residencies, but is becoming true also for internships and clinical clerkships. The accrediting agencies are requiring more sub-specialty clinics, a richer variety of clinical cases, more depth in training, more faculty members with board eligible training, more complementary programs in allied disciplines, and a wide range of other specialties. Often a community hospital finds itself shy in one or another aspect for a particular residency and is therefore denied accreditation entirely; yet it might have corrected deficiencies by affiliation and sharing of resources.

When one program is lost, other programs also suffer and their acceptability may be jeopardized. For example, disaccreditation of the residency in internal medicine not only costs the hospital a most important and basic residency, but also causes loss of existing or potential straight internships in medicine. In addition, it also jeopardizes residency programs in other specialties—if not by the accrediting body itself then by a boycott of prospective candidates for these other residencies who will prefer to go to a place where *all* the training programs exist and the educational experience for *all* house officers in *all* fields is thereby enhanced.

Types Of Affiliations

Several types of affiliation of community hospitals have been successful.

A. Affiliation of community hospitals *within* the community or region. This type of affiliation has been tried in:

1. *Pittsfield, Massachusetts:* Two hospitals affiliated several years ago and formed a joint committee for education. Since then, they have developed approved residencies in several fields, plus an approved internship program. They are affiliated with Albany Medical College for teaching and for residency training.

2. *Jacksonville, Florida:* Here six hospitals are involved. These include public (county) hospitals as well as private (voluntary) hospitals. They also were able to affiliate with a medical school. Yet, mediocrity existed when each hospital operated its educational program independently.

3. *Catholic Medical Center, Queens and Brooklyn, New York:* There, five Catholic hospitals joined in an educational venture combining resources and personnel. This arrangement includes many full-time clinicians as well as directors of medical education and full-time (Ph.D. level) research people. The excellence of the resulting program is attested to by the number and variety of residency programs already approved.

* Director of Medical Education at Morristown Memorial Hospital, Morristown, New Jersey, and member of Task-force Committee on Stroke, New Jersey Regional Medical Program.

B. Interesting as a type or complete affiliation is that in Wilmington, Delaware where three community hospitals actually joined in corporate *merger*. They pooled *all* assets and liabilities and became completely integrated. As a by-product of this (for it was not the original reason for the merger), an improved educational program resulted. There is now a program of graduate education comprising several residencies, where formerly the programs in each of the three hospitals were either nonexistent, in danger of losing accreditation, or poorly filled.

C. Affiliation with a medical school. This of course, is the real goal of all community hospitals—the final sustaining nourishment of dying or severely anemic educational programs in community hospitals. But demands on medical schools for such affiliation are legion. Naturally, the schools select the ones which they feel will best serve their purposes, assuming other considerations as distance and facilities for board and lodging are satisfied. Here, innovations and a fresh approach will be recognized. Affiliations such as those listed in Part A above will be looked upon favorably for, among other reasons, the following:

1. Pooling resources gives better local facilities for the residencies which are considered important in the influence such programs have on the organization and conduct of clinical clerkships for students.

2. Ability of several hospitals to affiliate for educational programs bespeaks a frame of mind and progressiveness which augurs well for success of affiliations between these hospitals and *other* organizations such as the medical school.

3. Ability to affiliate and regionalize for educational purposes also predicts a flexibility which will be useful in participation of these institutions in regional medical programs (RMP) as they are developed and so the medical schools who are also very much interested in the opportunities offered them by RMP will be drawn to this type of community hospital.

The Regional Medical Programs (Public Law 89-239) in most areas are now working under planning grants. One important provision relates to education of health personnel and continuing education of physicians, both of which are basic to another aspect of the act: adequate delivery of patient care to more of our citizens. If community hospitals demonstrate a willingness to start innovative methods of education—by affiliations or by other means—it is probable that funding could be secured from the Regional Medical Program for a continuing education program. In addition, community hospitals should consider the training of other health personnel. Many already train nurses, laboratory technicians, and x-ray technologists. Why not add other programs, form a *College of Allied Health Sciences* and affiliate with a local university?

While these possibilities do not infringe enlarge diagnostic laboratories (funds for contruction are even available under both P.L. 89-239 and Hill-Burton) since the intent of RMP is to provide *teaching* laboratories in community hospitals to accomplish the above aims.

While these possibilities do not infringe wholly on a hospital's *graduate* medical education programs, they certainly influence them both directly and because of the indirect effect they will have in placing the hospital in a favorable position as concerns affiliations with medical schools and/or other hospitals for educational purposes.

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2. "Proceedings: Conference on Regional Medical Programs," Public Health Service, U.S. Department of Health, Education and Welfare, Washington, D.C. 1967.

3. Proceedings, 64th Annual Congress on Medical Education, AMA, Palmer House, Chicago, 1968.

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100 Madison Avenue

There are, says Dr. Galen, no medical or psychiatric grounds for the use of LSD in private practice.

Legal Implications Of LSD*

Noel C. Galen, M.D./Englewood

The use of hallucinogenic drugs seems to be extremely threatening to western culture. The revulsion and antagonism that has been heard over the recent increase in drug taking has found its expression in the law which is sensitive to (and is a result of) changing social values. Thus psychiatry and law have found another interface with which to struggle: the use, control, regulation, and restriction of the hallucinogenic drugs. LSD was developed in a scientific manner with high hopes that it would become a useful and meaningful therapeutic tool. Essentially its use was medical and directed for the patient's good. With its popularization it has become a social phenomenon and because its implications have been so threatening to our pragmatic and goal-directed society and because of the (by now obvious) medical dangers, there is now a rush of legislation to control it. On May 15, 1968, the United Nations Economic and Social Council adopted the first comprehensive international measure on the use and manufacture of LSD. The Council urged all member nations to prohibit use of LSD except in controlled medical research, and to prohibit *all* import or export of hallucinogens. There is no federal law concerning LSD as such, other than regulations concerning its purity. I would assume that if someone sold impure LSD he would then be vulnerable to federal prosecution, but not if he sold pure LSD.

Most states (including New Jersey) have laws which are directly concerned with LSD. Several bills now pending in our legislature are specifically concerned with LSD regulation. A bill now before the New Jersey Senate would impose severe penalties for possession, sale, or manufacture of LSD. Anyone convicted of selling (or giving) a hallucinogenic drug to a minor would face a *minimum* sentence of 10 years in prison and a $2000 dollar fine. The maximum penalty could be life imprisonment. Other penalties under this bill include prison sentences up to 15 years and fines up to $2,000 for anyone convicted for the first time of selling LSD to adults, or possessing, using, or manufacturing hallucinogenic drugs. Second convictions would bring sentences up to 25 years, fines up to $25,000. Prison sentences for subsequent convictions could include life imprisonment. Among other measures now also before the Assembly is a bill which would give law enforcement officials the right to remove the driver's license of a convicted user of hallucinogens. The severity of these measures is an indication of the fear and threat that LSD poses to our culture.

In New York State the *use* of LSD is a misdemeanor but *selling* LSD is classed a felony.

Several interesting changes in the usage of LSD have taken place during the past year. At Bellevue, the number of acutely disturbed admissions has dropped off, and in my own meager private series there has been a sharp drop in its usage and serious sequelae. This may be due to the massive public information program on the ill effects of LSD, or perhaps, the dosages by the users are more regulated.

One aspect of LSD usage, not ordinarily discussed, is the administration of LSD to an unsuspecting person, without his knowledge. This has happened on at least two occasions that I personally know about. Results were

*Read before the Section on Psychiatry and Neurology, Annual Meeting, The Medical Society of New Jersey, Atlantic City, May 20, 1968.

disastrous. I agree with the recommendation of the Medical Society of New York (policy statement of January, 1968) that this is a particularly heinous offense and that this should be classified as a felony.

There is, at present, no law which makes it imperative that LSD use by private patients is reportable to the State Department of Health. And there is no federal law pertaining to the hallucinogens.

Behind some of the controversy in the legal control of the hallucinogens is a fundamental issue of civil rights. Thus it is argued by many intellectuals that persons have a right to do what they wish in the privacy of their own homes, even to engage in an activity that is potentially harmful to them. One well known psychiatrist went so far as to say that all people have a right to commit suicide if they wish; and that to deprive them of this is depriving them of their civil rights. This argument is felt by many to have some merit; we certainly cannot legislate against all of man's self-destructive tendencies or we would have to prohibit all that is sinful or fattening. But as far as LSD is concerned, it is difficult to justify that argument since society must pay the price, either by treating patients made ill by this drug, supporting them in public hospitals, or by supporting their families. Also, society must lose the production potential of the sick LSD user.

As a result of the civil rights approach, however, there have been strong attacks on restrictive laws on LSD. In California (where a strong anti-LSD law was passed in 1965) there has been continuing opposition from within the medical community. Many physicians would like to see drug abuse as a clearly medical problem which should be handled far away from the courts. According to Dr. David Smith, director of the Haight-Ashbury Clinic, "From a medical point of view, a drug has no moral value — it is neither good nor bad, but rather is used or abused and all drugs have an abuse potential." Dr. Smith suggests that drug laws should form a continuum based on the danger of the drug and its abuse potential.

The use of LSD is completely contra-indicated in the private practice of medicine at this time and there are today no medical, clinical, or psychiatric grounds for its use in anything other than research. The overwhelming evidence is that it is far too dangerous to be used other than in the most controlled research conditions.

In my opinion the following recommendations would help in dealing with some of the problems connected with LSD.

1. The present laws under consideration concerning LSD should be very carefully evaluated.

2. A mandatory reporting system should be set up through the State Department of Health so that accurate data can be collected on incidence.

3. Federal laws should be enacted covering the interstate transportation of hallucinogens.

4. A medical advisory board should be set up to help advise the Governor on drugs which are dangerous or addicting and which may have to be controlled by legislation.

5. A committee should be formed by The Medical Society of New Jersey to evaluate the ongoing effects of current legislation.

6. This committee should be composed of physicians, legislators, sociologists, and statisticians.

7. Our State Medical Society and other state medical organizations, together with the appropriate paramedical societies, should take the lead in helping the legislature write meaningful, helpful, and just laws about drugs.

200 Engle Street

NEW JERSEY DOCTORS' NOTEBOOK

Trustees' Minutes

December 22, 1968

A regular meeting of the Board of Trustees was held on December 22, 1968 at the Executive Offices in Trenton. Detailed minutes are on file with the secretary of your county medical society. A summary of the significant actions follows:

Health Facilities Planning Council . . . Directed that the name of John F. Kustrup, M.D. be submitted for renomination as one of MSNJ's representatives on the Health Facilities Planning Council.

Medicaid . . . Directed that a statement be prepared for presentation at the public hearings on the Medicaid Program in New York, and authorized — if the situation warranted — attendance of the President, the Executive Director, and the Executive Assistant.

. . . Directed that a nucleus negotiating committee be formed (President, President-Elect, and Chairman of the Council on Medical Services — to be expanded at the discretion of the committee) to work with the State Medicaid Commission to be established when S-850 is signed into law.

C. Byron Blaisdell, M.D. . . . Directed that an appropriate resolution be prepared honoring Dr. Blaisdell's distinguished service as an AMA Delegate, and that a copy be sent to the AMA. (With his work at the 1968 AMA Clinical Convention, Dr. Blaisdell ended 30 years' service.)

Secretary, MSNJ . . . Was pleased to note that Dr. Marcus H. Greifinger is resuming responsibility for the duties connected with the office of Secretary of the Society. Felicitations and good wishes will be sent to Dr. Greifinger and to Dr. Jerome Kaufman who has been serving as Secretary *pro tem.*

Conference on Mental Health . . . Approved the recommendation from the Council on Mental Health that the Chairman of the Committee on Emotional Disorders of Childhood and Adolescence (Eugene V. Resnick, M.D.) be designated as official representative of MSNJ at the 15th Annual Conference of State Mental Health Representatives to be held in Chicago, March 14 and 15, 1969.

Obstetrical and Gynecologic Patients . . . Approved the recommendation of the Committee on Maternal and Infant Welfare that MSNJ continue to approve, in principle, the mixing of obstetrical and gynecologic patients, provided all recommended criteria be strictly observed and that an adequate form of regular external inspection by a competent agency be maintained.

Report of AMA Delegates . . . Referred the following items from the report of the AMA Delegates (1968 Clinical Convention) to the Committee on Revision of Constitution and Bylaws:

1. *Relations with Osteopathy* — The AMA House of Delegates has adopted a report urging that there be made available to students and graduates in osteopathy education of the same high standards as prevail in undergraduate, graduate, and continuing educational programs in medicine, and to provide avenues through which qualified osteopaths may be assimilated into the mainstream of medicine; and suggesting that each county and state medical society may accept qualified osteopaths as active members and thereby provide for their membership in the AMA.

2. *AMA Membership Classification* — The AMA House of Delegates urged that county and state medical societies adopt the membership classification used by the AMA.

ANNUAL MEETING

May 17-20, 1969

Haddon Hall

Atlantic City

PHYSICIANS SEEKING LOCATION IN NEW JERSEY

(Listed in order of receipt)

The following physicians have written to the Executive Offices of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly of them.

INTERNAL MEDICINE—Harvey I. Hurwitz, M.D., Apt. L-2, 121 South Highland Avenue, Ossining, New York 10562. Boston University, 1962. Board eligible. Group. Available.

Raymond L. Hargrove, M.D., 44 Norman Place, Box 113, Tenafly, New Jersey. University of Pennsylvania, 1961. Board eligible. Subspecialty, Gastroenterology. Group. Available July 1969.

Allen B. Bredt, M.D., 3509 Foxcliffe Court, Randallstown, Maryland 21133. University of Pennsylvania, 1962. Board eligible. Subspecialty, Malignant Hematology and Cancer Chemotherapy. Available July 1969.

David A. Berkowitz, M.D., 2408A Snark Street, Griffiss AFB, New York 13440. New York Medical, 1963, Board eligible. Group or partnership. Available July 1969.

OBSTETRICS AND GYNECOLOGY—Donald S. Cohen, M.D., 2512A Atlas Drive, Griffiss Air Force Base, New York, 13440. Columbia, 1962. Board certified. Partnership or group. Available July 1969.

Harold M. Yatvin, M.D., Kirk Army Hospital, Aberdeen Proving Ground, Aberdeen, Maryland 21001. New York Medical, 1962. Board eligible. Group. Available August 1969.

Jerry A. Wider, M.D., 315 Congressional Lane, Rockeville, Maryland 20852. Columbia, 1963. Board eligible. Partnership or Group. Available July 1969.

Ronald P. Portadin, M.D., 296-B Bizerte Road, Fort Lee, Virginia 23801. Georgetown, 1962. Board eligible. Associate. Available July 1969.

OPHTHALMOLOGY—Franklin L. Bocian, M.D., 54 Orange Street, Brooklyn, New York 11201. Downstate Medical Center (NYU), 1964. Solo or associate. Available July 1969.

PATHOLOGY—Martin Berman, 6309 Winner Avenue, Baltimore, Maryland 21215. Downstate Medical Center (NYU), 1961. Board certified. Group, partnership, institution. Available July 1969.

SURGERY—Teofilo Po, M.D., 5235 Post Road 2-C, Riverdale, New York 10471. University of Santo Tomas, Manila, 1958. Board certified. Solo or group. Available April 1969.

UROLOGY—William A. Reed, Jr., M.D., 168 Grove Park, Fort Dix 08640. Georgetown, 1958. Board certified. Partnership or group. Available December 1968.

Albert P. Parasuk, M.D., 350 East 17th Street, New York, New York 10003. George Washington, 1964. Associate. Available July 1969.

Alfred R. Bozzo, M.D., 3106 Holly Street, Alexandria, Virginia 22305. Georgetown, 1962. Board eligible. Solo or partnership. Available July 1969.

Guidelines On Transplants

Ethical guidelines concerning organ transplants, submitted by the AMA's Judicial Council, were recently approved by the House of Delegates.

According to the Judicial Council's opinion, "A man in the final analysis, must make a decision whether to permit or to perform a transplantation procedure. The decision must be a reasoned, intellectual conclusion, not an emotional decision. As medical science advances, and as technologic skill increases, the ethical questions involved may become increasingly complex and difficult."

The Council offers the following statements for the guidance of physicians as they seek to maintain the highest level of ethical conduct in their practice:

Since the physician's primary concern is the health of his patient, care must be taken to protect the rights of both the donor and the recipient. No physician may assume the responsibility in organ transplantation unless the rights of both donor and recipient are equally protected.

A prospective organ transplant offers no justification for relaxation of the usual standards of medical care. The physician must provide a prospective organ donor with the same care usually given others being treated for similar injury or disease.

When a vital, single organ is to be transplanted, the death of the donor shall have been determined by at least one physician other than the recipient's doctor. Death must be determined by the clinical judgment of the physician, using all available, currently accepted scientific tests.

There must be full discussion of the proposed procedure with the donor and the recipient or their responsible relatives or representatives. The physician's interest in advancing scientific knowledge must always be secondary to his primary concern for the patient.

Transplantations are to be undertaken only by those physicians who possess special medical knowledge and technical competence and in medical institutions with facilities adequate to protect the health and well-being of the parties to the procedure.

Transplants should be undertaken only after scrupulous evaluation of the availability and effectiveness of other possible therapy.

Discreet public reports to the communications media may be made by an authorized physician but should be followed as soon as possible by full scientific reports to the profession.

The Judicial Council adds that reporting of medical surgical procedures should always be objective and factual. In turn, such reporting will enhance the stature of the medical profession and its service to mankind.

New Provisions For Physician-Employers

If you employ a nurse, secretary, technician, or any other worker, you will be interested in changes in our State's unemployment compensation law. In making the announcement Edward J. Hall, director of the New Jersey Division of Employment Security, explained that the legislation provides that employing units having one or more individuals (in covered employment) and having paid remuneration in the amount of $1,000.00 or more during any calendar year, starting now, will be subject to the New Jersey Unemployment Compensation Law. Some 50,000 additional employers will be affected and an additional 100,000 workers will be afforded the protection of unemployment compensation and temporary disability benefits.

Employers under this change will pay a basic rate of 2.8 per cent for unemployment insurance and ¼ of 1 per cent for disability insurance coverage on the first $3,600 paid to an employee during the calendar year. Worker contributions are ¼ of 1 per cent for unemployment insurance and ½ of 1 per cent for disability insurance. Employers are responsible for deducting worker contributions beginning the day after accumulated 1969 remuneration for all employees totals $1,000 or more. Quarterly contribution reports, covering both employer and worker liability, must be submitted to the Division of Employment Security during the month following the end of each calendar quarter.

The Division has obtained from the Internal Revenue Service and the Social Security Administration a list of all employers filing withholding tax and social security returns during the year 1968. This list will be used for mailing informational reports to the potential new "employers." If you do not receive this report (Hall stated) you are not relieved of liability to comply with the amended unemployment compensation law of New Jersey. Report forms can be obtained at the regional auditors' office located as follows:

Atlantic City (08401)
Boardwalk and Tennessee Avenue
(609) 348-1171

Camden (08103)
300 Broadway, Room 208
(609) 966-7279

Jersey City (07306)
363 Summit Avenue
(201) 653-6500

Paterson (07505)
224 Broadway, Room 200
(201) 274-7980

Newark (07102)
309 Washington Street, Room 401
(201) 648-3870

Perth Amboy (08801)
339 Maple Street
(201) 442-9393

Morristown (07960)
3 Schuyler Place, Room 203
(201) 539-2750

Trenton (08625)
Labor and Industry Building, Room 510
(609) 292-2638

Diabetes Exhibit Available



You may now obtain, without charge, a two panel exhibit (see illustration) in diabetes detection and automatic equipment. This is suitable not only for hospital conferences and staff training but also to "health fairs" and other medically sponsored showings to the public.

Write to the State Health Department a month prior to the date needed. Address your request to the New Jersey State Department of Health, Division of Graphic Arts, Box 1540, Trenton, New Jersey 08625. Please include all details for delivery (including the name of the person to whom delivery should be made) and the set-up and break-down time. The Department will not only lend the exhibit, but will even deliver and set it up.

Eye Screen Program

Our "Eye Health Screening" program has just completed its twelfth year. In 1957, only 4,062 people were "screened." In 1968 the number was 11,659. There were 5,243 "positive" findings, which comes to almost 50 per cent of the number screened. Glaucoma was picked up in 60 of these subjects. We now have 85 participating centers—the largest number ever. In New Jersey, the eye health screen has proved itself!

Communicable Diseases In New Jersey

The following communicable diseases were reported to the Division of Preventable Diseases during the month of December:

	December 1968	*December 1967*
Aseptic Meningitis	11	4
Primary and Post Infectious Encephalitis	1	4
Hepatitis:		
(a) Infectious	135	85
(b) Serum	20	19
Malaria	2	14
Meningococcal Meningitis	14	7
Mumps	343	1155
German Measles	33	51
Measles	33	94
Salmonella	46	39
Shigella	23	13

Influenza

Since mid-November A2/Hong Kong/68 virus has been verified among residents in nine counties in New Jersey. Influenza-like illness has been reported in ten other counties, manifested chiefly by increased absenteeism due to febrile respiratory illness. Laboratory results from these counties are pending. Most of the illnesses reported from schools, hospitals, colleges, and institutions have been mild.

Week of (1968)	*First Reports of Flu-Like Illness*	*Counties where Influenza A2/Hong Kong/68 was confirmed*
Nov. 10	Burlington	Burlington
Nov. 17	Camden, Mercer, Salem	Camden, Mercer
Nov. 24	Atlantic, Middlesex	Atlantic, Middlesex
Dec. 1	Bergen, Essex, Gloucester	
Dec. 8	Hudson, Hunterdon, Monmouth, Morris, Ocean, Passaic, Somerset, Union, Warren	Morris

A rise in mortality above the expected upper tolerance limit was first reported for the week beginning December 1. It is felt that this escalation was due to deaths from secondary complications following influenza in older people with pre-existing heart or lung disease. Infection with Influenza A2/Hong Kong /68 has been confirmed in five cases of pneumonia. Three were fatal, and in these cases, influenza virus was isolated from bronchial smears.

Outbreak of Salmonellosis

Salmonellosis involving all 18 persons who attended a family Thanksgiving dinner in Jersey City occurred on November 28 and 29, 1968. Ages ranged from 7 months to 56 years. Onset of illness was 3 to 17 hours after the meal, with a median incubation period of 7 hours. Symptoms included vomiting (100 per cent), diarrhea (100 per cent), fever (94 per cent), and abdominal pain (82 per cent). As a result of the outbreak, 16 persons were hospitalized. Mean duration of hospitalization was greater than 6 days. Two victims died as a result of the outbreak. A 17 year-old boy died at home 37 hours after his onset of illness; his mother, a 56 year-old woman, died in the hospital 3 days after onset of her symptoms. Cultures from all those involved including the asymptomatic person who consumed part of the meal and a pet dog (which died) were positive for *Salmonella enteritidis.*

The meal was a traditional Thanksgiving dinner including turkey and stuffing. All foods were consumed by nearly everyone at the meal and food histories did not implicate a single vehicle. Cultures of leftover turkey, stuffing, and gravy yielded *S. enteritidis* in very high concentration.

The 23 pound frozen turkey was purchased on November 23. It was thawed by moving it from the freezer to the bottom of the refrigerator during the morning prior to Thanksgiving Day. It was cooked at 300 degrees for 7 hours and consumed immediately afterward. The stuffing contained grade A medium eggs, bacon, fresh Italian sweet sausage, bread, and giblets from the turkey. The gravy was a commercial product heated just prior to dinner. Following the outbreak, the partly consumed turkey was examined and was noted to be markedly undercooked. Although the turkey may have been the vehicle causing this outbreak, the possibility that the sausage or the eggs were the vehicle has not been excluded.

Salmonella gastroenteritis is usually a mild, self-limiting illness, with rare fatal cases among infants, the elderly, and persons with

underlying medical problems. Although virulence cannot be assessed, *S. enteritidis* is a salmonella serotype which has been known to cause serious illness. The severity of this outbreak probably was due to a very heavy inoculum of salmonella. This unusually large inoculum (revealed by the quantitative studies of the contaminated foods) probably also caused the atypical incubation period and attack rate.

Training For Ambulance Personnel

The Committee on Emergency Medical Services of the National Research Council has recommended a nationwide program for the training of ambulance personnel.

The committee proposed guidelines for such training, stating that there is at present "no uniformity in the course of instruction and . . . no generally accepted standards of proficiency to be used by those empowered to certify ambulance personnel." These guide lines cover: the first aid courses of the American National Red Cross as a prerequisite, the operation of emergency vehicles, safety precautions at the accident scene, priorities of care, records, the use of communication systems, the use of equipment and supplies, medicolegal problems, and rescue procedures.

The levels of proficiency designed to result from the course are attainable in most areas of the country within a reasonable time, the committee said. However, to realize the greatest life-saving potential, the ambulance attendant of the future should be trained to the same level as lay assistants in emergency departments or medical corpsmen in combat areas; and, ideally he should be qualified to carry out, either independently or through voice communication with a physician, such procedures as tracheostomy, defibrillation, and mechanical external cardiac compression.

To attain these goals, the committee said, accredited hospital training programs must be established that will produce professional ambulance attendants and emergency department assistants of the caliber of certified x-ray, laboratory, physical therapy, and other accredited medical technicians.

The ambulance attendant, it added, must be fully engaged in emergency care in an established career pattern that provides attractive compensation, prestige, and recognition deserving of his services as a member of the emergency care team. Where the needs for ambulance services are low so that he is not fully occupied, such as in small communities, he should be an employee of a hospital, where he can maintain his interest and proficiency as an assistant in the emergency department, intensive-care unit, or operating room.

Share Your Medical Journals

You are being asked to send your medical journals (after you have read them) to colleagues overseas. They wish access to current medical literature but, either because of currency regulations or actual cost involved, cannot themselves subscribe to medical periodicals. The name, address, and medical specialty of doctors in these areas who would be happy to receive these much wanted journals (particularly specialty journals) can be supplied to you.

This is a direct "Doctor-to-Doctor" program which is being sponsored by the AMA with the collaboration of The World Medical Association to help alleviate the lack of current medical publications and to further international good will. Your cooperation in this program will be greatly appreciated, and your contact with these colleagues in other countries, we can assure you, will prove very gratifying. If you wish to participate in this program, send your name, address, and the titles of journals you will contribute to: Doctor-to-Doctor Program, The World Medical Association, 10 Columbus Circle, New York, New York 10019.

ANNOUNCEMENTS

Treatment of Anal Ulcer and Hemorrhoids

On March 5, 1969, a program will be offered on the surgical treatment of anal ulcer and hemorrhoids. The guest speaker is James A. Ferguson, M.D., Chief of Colon and Rectal Surgery at the Ferguson Clinic, Grand Rapids, Michigan. The meeting is sponsored by the Pennsylvania Society of Colon and Rectal Surgery, and will be held at the Union League, Broad and Sansom Streets, Philadelphia. There is a reception at 6:30 p.m., followed by dinner at 7:30 p.m. You may make reservations by mailing a check for $12.50 to Valentine R. Manning, Jr., M.D., 3336 Aldine Street, Philadelphia.

Christian Medical Society

On Friday, March 7, 1969 at the Neptune Inn, Route 4, Paramus, New Jersey, the Christian Medical Society will hold a dinner meeting at 7 o'clock for physicians, dentists, and medical and dental students. Wives and teenage children are invited, and it is suggested that you bring your pastor as a guest. The program will be of particular interest to teenagers questioning "the establishment." Wayne H. Finley, M.D. of the University of Alabama Medical Center will speak on the chromosomal effects of drugs. A well-known entertainer will discuss his commitment to Christian life as the solution to his alcohol and drug addiction problems. For further information and reservations, write to the Christian Medical Society, P.O. Box 245, Ridgewood, New Jersey 07451, or call (201) 447-1620. The tickets are $8 (less for students).

Graduate Institute In Philadelphia

The Philadelphia County Medical Society will hold its Thirty-Third Annual Postgraduate Institute at the Marriott Motor Hotel, City Line West of the Schuykill Expressway, March 31 to April 2, 1969. Topics to be covered include, "Coronary Artery Disease," "Recent Advances in Gastro-enterology," "Rheumatism," and "Medical and Surgical Oncology." An array of talented experts will comprise the faculty. Special programs are being planned for the wives of the physicians who attend. This meeting is approved by the American Academy of General Practice. A complete program will be mailed shortly.

The Director of the Institute is Dr. Charles Shuman, Professor of Medicine, Temple University Medical Center. Address all inquiries to him at 2100 Spring Garden Street, Philadelphia, Pa. 19130.

The Old Helping Hand Organization

Many of the younger doctors do not know that there exists in our state a unique helping hand organization, known as the Society for the Relief of the Widows and Orphans of Medical Men in New Jersey. This organization provides immediate financial assistance to the dependents of a deceased member. It lends money without interest to assist widows and orphans of doctors who have known adversity.

For details, write to the Society at P.O. Box 95, Belleville, New Jersey.

OBITUARIES

Dr. Edwin J. Allen

November 29, 1968 marked the death of Edwin J. Allen, M.D., a prominent Passaic County orthopedist. Dr. Allen received his M.D. at the University of Geneva in Switzerland in 1937. He was affiliated with the Paterson General Hospital, and was active in the field of industrial surgery. He was 61 at the time of his death.

Dr. William E. Bray

One of Burlington County's distinguished physicians, William Emory Bray, died on January 11, 1969. Dr. Bray was the founder and long-time editor of the Newsletter of the Burlington County Medical Society. He won national attention for his contribution to the control of cancer and received a medal and plaque from the American Cancer Society in recognition of this. He was a member of our State Society's House of Delegates for many years, and served on major committees. Dr. Bray was born in 1908 and received his M.D. from the Medical College of the State of South Carolina in 1933. Following internship, he moved to our state and served the people of New Jersey ever since. Dr. Bray was president of the Burlington County Medical Society in 1946-1947, and was active in civic and church affairs in South Jersey.

Dr. Maurice Cohen

Montclair lost one of its best known physicians on November 27, 1968 with the death on that date of Maurice Cohen, M.D. Born in 1893, he was a graduate of the University of Vermont Medical School in the class of 1916. Dr. Cohen was noted as the very model of the family doctor. For many years he was on the staff of the Mountainside Hospital, becoming affiliated there shortly after that hospital's establishment. Dr. Cohen remained a general practitioner, and was involved in many civic activities in west Essex.

Dr. Richard C. Drewes

The war in Viet Nam took the life of our fellow-member, Richard C. Drewes, M.D., Captain, MC, AUS. This tragedy occured on December 17, 1968, when the plane on which he was riding, going home for discharge after long service with the 27th Surgical Hospital, was attacked by enemy ground fire. Born in 1933, he was only 35 years old at the time of his death. He was a general practitioner in Trenton, having been graduated in 1959 from Hahnemann.

Dr. Theodore K. Graham

The well known Paterson obstetrician and gynecologist, Theodore K. Graham, M.D., died on November 12, 1968. After graduation in 1931 from the New York Medical College and, following brief service as a general practitioner, Dr. Graham did graduate work in gynecology and obstetrics. He became a diplomate in both specialties and was affiliated with St. Joseph's Hospital in Paterson. Dr. Graham was 68 years old at the time of his death.

Dr. Jacob H. Hekimian

Born in 1889, Jacob H. Hekimian, M.D., died on December 5, 1968 at the age of 79. He received his medical degree at Tufts in 1917. Dr. Hekimian was a surgeon, on the staffs of the Christ Hospital and the Medical Center in Jersey City, as well as at the North Hudson Hospital in Weehawken. He was long active in the affairs of our Hudson County Component Medical Society.

Dr. Abraham L. Levy

For many years an East Orange practitioner, Dr. Abraham Levy retired to the Lake George area in New York State. And there, on November 29, 1968, after a long illness, he quietly slept his life away. Dr. Levy was a pioneer in geriatrics involving himself in that specialty in the mid 1920's when the word "geriatrics" was almost unknown. Dr. Levy was born in 1898, and was a 1920 Bellevue graduate.

Dr. A. Carfi Linares

Born in 1890, A. Carfi Linares, M.D., received his medical degree from the Royal University of Catania (Italy) in 1914. He was a well-known Paterson general practitioner. Dr. Linares died on November 29, 1968, at the age of 78.

Dr. Edward E. Lupin

Edward E. Lupin, M.D., was one of Bayonne's most prominent medical citizens. He served for many years as the Health Officer in Bayonne. Dr. Lupin was born in 1887 and achieved the grand age of 81 at the time of his death on November 29, 1968. He was a family doctor of the old school, and proud of his role as a family health counselor as well as a therapist. He was affiliated with the Bayonne Hospital. Dr. Lupin was awarded his M.D. at the University of Pennsylvania's Medical School in 1912.

Dr. Margot S. Mears

Only recently, Margot S. Mears, M.D., transferred her membership from the Philadelphia County to our Camden County Medical Society. She was born in 1937 and died at the age 31. Dr. Mears received her M.D. degree at the Woman's Medical College of Philadelphia in 1963 and did graduate work in orthopedics at the Temple University Hospital in Philadelphia. She then was invited to the Shriner's Hospital for Crippled Children and to the orthopedic service of Our Lady of the Lourdes Hospital in Camden. Just as this promising career was beginning to flower, it was cut short by her untimely death on November 30, 1968.

Dr. Otto Mustermann

On January 5, 1969 Otto H. Mustermann died in the 64th year of his life. He was a graduate of Columbia University's College of Physicians and Surgeons (class of 1928) and served on the surgical staffs of several hospitals in the Hudson County area. He was a Commander in the U.S. Navy during World War II. Dr. Mustermann was a FACS and a member of the New Jersey Society of Surgeons.

Dr. J. Gerald Pearson

One of Union County's early ophthalmologists, Dr. J. Gerald Pearson died on August 1, 1968. He was a graduate of Columbia University's College of Physicians and Surgeons in the class of 1928. Dr. Pearson was on the ophthalmological service at Elizabeth General Hospital. He was only 66 years old at the time of his death.

Dr. Samuel J. Pecora

A 1934 graduate of the medical school at the University of Louisville, Kentucky, Samuel J. Pecora, M.D. became a well known general practitioner in the Newark area. He was affiliated with Clara Maass, Columbus, and Newark City Hospitals. Born in 1907, he was 61 years old at the time of his death on December 5, 1968.

Dr. James S. Shipman

Long one of south Jersey's leading ophthalmologists, James S. Shipman, M.D. died on January 3, 1969, at the age of 70. A native of Mississippi, Dr. Shipman earned his M.D. degree at the medical school of the University of Pennsylvania in 1924. He settled in the Camden area where he soon become active in medical society and civic affairs. Dr. Shipman was a past-president of the Camden County Medical Society, and associate professor of ophthalmology at his alma mater. He was an early diplomate of the American Board of Ophthalmology, and a Fellow of the American College of Surgeons.

Erratum

In the January issue of this Journal we reported the death of Philip D'Ambola on November 5, 1968. Due to a typographical error we listed Dr. D'Ambola's birth year as 1922 when it was actually 1902. We are glad that his useful life was not really terminated after so brief a career, but in fairness to the family we acknowledge and regret this error.

MEETINGS OF MEDICAL INTEREST

This listing has been compiled by the Academy of Medicine of New Jersey. For additional information, including exact time of meetings, write to the society or hospital listed.

1969
February

11 **Bergen County Medical Society**

11 **Cumberland County Medical Society**

12 **Mercer County Medical Society**
State Hospital
Trenton

12 **Essex County Heart Association**
St. Barnabas Medical Center
Livingston

12 **Gloucester County Tuberculosis and Health Association**

12 **Middlesex County Medical Society**

12 **Ocean County Medical Society**

14-15 **American College of Surgeons**
New Jersey Chapter
Trip to Cleveland Clinic
Cleveland, Ohio

18 **Warren County Medical Society**

19 **The Academy of Medicine of New Jersey and American Cancer Society, New Jersey Division**
Holiday Inn
Kenilworth
Symposium: "What's New in Cancer"

19 **Essex and Morris County Medical Societies with Sandoz Pharmaceuticals**
Sandoz Auditorium
Hanover
"Treatment of Ski Injuries"

19 **Middlesex General Hospital**
New Brunswick
"Hemodialysis for Renal Insufficiency"

20 **Gloucester County Medical Society**

20 **Morris County Medical Society**

26 **Bergen Pines County Hospital**
Division of Internal Medicine
Paramus
"Recent Advances in Cancer Chemotherapy"

26 **New Jersey Gastroenterological Society Newark**

26 to Mar. 1 **New Jersey Academy of General Practice**
Sheraton-Deauville Hotel
Atlantic City
Convention

March

4 **Hudson County Medical Society**
"Modern Concepts About Immunization"

7-9 **The Academy of Medicine of New Jersey and Bergen Pines County Hospital**
Marriott Motor Inn
Saddle River
"Current Concepts in Respiratory Disease"

11 **Bergen County Medical Society**

12 **Gloucester County Tuberculosis and Health Association**

12 **Mercer County Medical Society**
State Hospital
Trenton

12 **Middlesex County Medical Society**

12 **Ocean County Medical Society**

12 **Bergen Pines County Hospital**
Division of Internal Medicine
Paramus
"Gout and Uric Acid Metabolism"

12 **The Academy of Medicine of New Jersey**
Section on Basic Medical Sciences Symposium

19 **The Academy of Medicine of New Jersey**
Symposium: "Management of Gastrointestinal Hemorrhage"

19 **Bergen Pines County Hospital**
Division of Internal Medicine
Paramus
"Acute Leukemia"

20 **Gloucester County Medical Society**

20 **Morris County Medical Society**

20 **Essex and Morris County Medical Societies with Sandoz Pharmaceuticals**
Sandoz Auditorium
Hanover
"Rheumatic Fever: Diagnosis and Treatment"

25 **Hunterdon County Medical Society**

26 **Bergen Pines County Hospital**
Division of Internal Medicine
Paramus
"Diuretic Agents and Therapy"

26 **The Academy of Medicine of New Jersey and Roosevelt Hospital**
Roosevelt Hospital
Metuchen
"Pulmonary Diseases"

26 **New Jersey Gastroenterological Society**
St. Joseph's Hospital
Paterson
Regional Meeting

31 **Cape May County Medical Society**

April

1 **Hudson County Medical Society**
"Changes In Medical Care and Practice"

2 **The Academy of Medicine of New Jersey**
Section on Obstetrics and Gynecology
Symposium: "Gynecological Neoplasms"

2 **Bergen Pines County Hospital**
Division of Internal Medicine
Paramus
"Chronic IPT — Pathogenesis and Management"

8 **Bergen County Medical Society**

8 **Cumberland County Medical Society**

9 **Gloucester County Tuberculosis and Health Association**

9 **Mercer County Medical Society**
State Hospital
Trenton

9 **Middlesex County Medical Society**

9 **Ocean County Medical Society**

15 **Warren County Medical Society**

16 **Essex and Morris County Medical Societies with Sandoz Pharmaceuticals**
Sandoz Auditorium
Hanover
"Treatment and Management of Puberty, Pimples, and Adolescence"

16 **The Academy of Medicine of New Jersey**
Hoffman-LaRoche
Nutley
Pediatric Symposium

16 **The Academy of Medicine of New Jersey**
Section on Dentistry
VA Hospital, East Orange
Symposium: "The Dentist's Role In Facial Pain And Its Management"

17 **Gloucester County Medical Society**

17 **Morris County Medical Society**

23 **Bergen Pines County Hospital**
Division of Internal Medicine
Paramus
"Porphyrin Metabolism"

26 **Kessler Institute of Rehabilitation**
Mayfair Farms
West Orange
20th Anniversary Dinner

May

6 **Hudson County Medical Society**
Election of Officers

7 **Bergen Pines County Hospital**
Division of Internal Medicine
Paramus
"Present Day Treatment of Chronic Renal Disease"

13 **Bergen County Medical Society**

14 **Gloucester County Tuberculosis and Health Association**

14 **Mercer County Medical Society**
State Hospital
Trenton

14 **Ocean County Medical Society**

15 **Gloucester County Medical Society**

15 **Morris County Medical Society**

17-21 **MSNJ Annual Meeting**
Haddon Hall
Atlantic City

18 **The Academy of Medicine of New Jersey**
Symposium: "The Diagnosis of Life and Death"

20 **Warren County Medical Society**

21 **Bergen Pines County Hospital**
Division of Internal Medicine
Paramus
"Adrenalcortical Insufficiency"

22 **Essex and Morris County Medical Societies with Sandoz Pharmaceuticals**
Sandoz Auditorium
Hanover
"Genetic Factors Affecting Drug Response"

26 **Cape May County Medical Society**

27 **Hunterdon County Medical Society**

28 **Middlesex County Medical Society**

June

10 **Bergen County Medical Society**

10 **Cumberland County Medical Society**

11 **Gloucester County Tuberculosis and Health Association**

11 **Middlesex County Medical Society**

11 **Ocean County Medical Society**

12 **Mercer County Medical Society**
Annual Outing
Trenton Country Club
Trenton

17 **Warren County Medical Society**

19 **Gloucester County Medical Society**

19 **Morris County Medical Society**

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BOOK REVIEWS

Treatment of Parkinson's Disease and Allied Disorders, Warren V. Huber, M.D., Editor. **Treatment of Acquired Hemorrhagic Disorders,** Oscar D. Ratnoff, M.D., Editor. (Modern Treatment, Vol. 5, #2) New York, 1968, Hoeber Medical Division, Harper and Row. ($16 per year by subscription)

The first half of this book covers Parkinson's, Wilson's, and Huntington's Diseases, and Sydenham's Chorea. The development of a somewhat too detailed Disability Rating Scale leads to an excellent understanding of the disabilities of Parkinson's Disease and their physical therapies. Under "medical therapy" of Parkinsonism there is a concise historical development and a broad survey of the available drugs. L-DOPA could not yet be afforded a definitive statement. Selection criteria, contraindications, technics and sequelae of surgical treatment of Parkinsonism and related disorders are covered very adequately for the non-neurosurgeon. Useful therapeutic and diagnostic points are presented in the section on the "Eye in Parkinsonism." The chapter on Sydenham's Chorea is excellent, but that on the rare Huntington's Disease is written pompously.

The second half of the book (acquired hemorrhagic disorders) is organized under: acquired defects in coagulation excluding the fibrinogenopathies; defibrination syndromes (other than those of pregnancy) and fibrinolytic disorders; defibrination syndromes of pregnancy; disorders of blood platelets; nonthrombocytopenic purpuras.

The coverage of most of the material is very good, even though (except for the obstetrician) non-hematologists may have trouble finding what they are looking for; and hematologists who know where to find what they are looking for, may not find enough for their purposes. HYMAN W. FISHER, M.D.

Cancer — A Manual For Practitioners. Fourth Edition. W. Botsford, M.D. Editor. Boston, 1968, American Cancer Society. Pp. 408 ($3.00 — hardbound, $2.00 — Paperback)

You will find here a comprehensive manual dealing with all phases of cancer. The chapter discussing the epidemiologic aspects is extremely valuable, as were, the discussions of pathology, biopsy, and para neoplastic syndromes. The list of contributors is a formidable one and they have done a most impressive job. This manual may find its largest use as an aid to doctors who have occasion to counsel patients, and for students.

The discussion of diagnosis did not stress firmly the principle of periodic examination as our most potent device in obtaining cures, since early detection still offers the best chance of survival. In general, this manual is highly recommended. My only suggestion is the use of larger print for those of us crossing the presbyopic threshold. EARL KANTER, M.D.

Brain Storms, Wayne Barker, M.D. New York, 1968, Grove Press. Pp. 277 ($7.50)

Even the most materialistic or "objective" of physiologists and neurologists must have observed that, at times, intuition, hunches, sudden creative or imaginative activities, and other evidences of a kind of cerebral spontaneity dominate one's thinking. Most observers credit this with some kind of mystical or, at best, parapsychological explanation. Barker, however, looks to cerebral physiology to explain it. He sees the brain as a complex machine, somewhat like a computer, seeking to retain a balance between input and outflow, and seeking to circumvent any blocking of its smooth flow of activity. To by-pass such blockages, the cerebral process engages in a whirlpool of activity (the "brain storm"), which is as much a "fit" in the thought processes as a convulsion is a fit in motor activity. Thus we are here presented with an effort to explain the unthinkable in the lexicon of the neurophysiologist. ABRAHAM LEFF, M.D.

Clinical Aspects of Operable Heart Disease. Donald R. Kahn, M.D., Ruth H. Strang, M.D., & William S. Wilson, M.D. New York, 1968, Appleton-Century-Crofts. p. 363.

Less than twenty years ago, this reviewer was assured by an eminent professor of surgery that the furthest limits of conceivable surgical exploration had already been reached — after all, one couldn't possibly operate on the heart itself.

Yet, here is a textbook dealing with the *clinical* aspects of *operable* heart disease whose last chapter devotes itself to the clinical problems posed by total heart replacement.

The authors state in their preface that this book is an attempt to summarize information on surgically amenable heart disease which is of importance to clinicians.

As such, this book succeeds very well. The general chapter organization as well as the arrangement of the material within each chapter tend to make the material presented very clear to the reader. Unlike many texts, very faithful reproductions of EKG's and X-rays supplement the text and there are good line drawings of the X-rays and of operative procedures as well.

The book's format also reflects careful preparation. The size of the book is convenient, the type is clean and legible throughout and the paper is non-glare and is easy on the eyes.

There are defects in every book, but very few in this one. However, some mention might have been made in the chapter on Methods of Diagnosis of the authors' opinions on the use of phonocardiography. Also, some information on the patient-age one might expect trouble from various lesions would have been an additional plus. The incidence of the various entities by sex might also have been useful.

For the practicing clinician, the surgical resident beginning to deal with cardiac surgical problems, or medical students curious about surgical heart disease, this book provides an excellent up to date summarization and a good set of references which enable further pursuit of knowledge if that is desired.

WM. A. DWYER, JR., M.D.

Parents and Children Learn Together. Katherine Whiteside Taylor, New York, 1967, Teachers College, Columbia University. Pp. 329 ($3.95)

This is a revision of a previous book entitled *Parent Cooperative Nursery Schools.* The text makes one aware of the importance of learning in the early formative years. The glaring example of pre-school education in the past few years has been Federal sponsorship of the "Head Start" programs for the underprivileged.

The author's purpose is to bring us up to date on the movement to form private cooperative nursery schools, especially geared to help parents understand pre-school children. It purports bringing parents together for mutual aid in rearing children early to creative purposefully activity. It is also a plea for further emphasis on educating teachers to help parents of the pre-school child and act as a director or liason between parents of each cooperative.

Although a book of soft cover and handbook nature, the material is quite detailed, beginning with early chapters on the learning, development, emotions, and needs of young children. The material then extends to include parental learning and understanding, organization and dynamics of a parent cooperative, and, finally, the socio-educational aspects of them. The author recommends the economics of these cooperatives be kept at a minimum by usage of the special talents, ingenuity, and participation of the parents involved in each cooperative.

The book is expressly recommended for parents and teachers but would also be of value to social workers, psychologists, and physicians dealing with children.

FRANK C. VANNORE, M.D.

A Doctor's Approach to Sensible Dieting and Weight Control. Paul G. Neimark and Eugene Scheinmann, M.D. Chicago, 1968, Budlong Press. Pp. 115. Illustrated. (paperback — $1.50).

Many physicians are deluged by patients seeking help with the great American problem of obesity. Publishing houses and drug companies flood the market with diet manuals, calorie counters, and exercise programs Yet this concise and logical paperback merits the special attention of doctors who seek to provide a written common-sense approach to dieting to save valuable office time and to provide answers to the most important questions asked on the subject. The first merit of this work is its emphasis on the uselessness of fad diets and the dangers of excessive use of diet pills. The simple language and short chapters will keep the patient's attention.

The great failing of this book is its lack of understanding at how hard it is for the average fatty to stop compulsive eating. Many would disagree with its thesis that "overweight is not really a disease," particularly if one relates alcohol and drug addiction to food addiction. This book assumes that most people can lose weight with nature's help and just a little effort. Also disappointing was the sparseness of information on the beneficial effect of properly prescribed and properly controlled appetite suppressants. The merits of these should be made as clear as are the disadvantages.

Taken as a whole, however, this is an excellent middle-of-the-road approach for the average patient.

ROBERT M. LIVINGSTON, M.D.

The Care of the Rheumatoid Hand. Second Edition. Adrian E. Flatt, M.D. Saint Louis, 1968, Mosby. Pp. 234. Illustrated ($14)

This book includes material concerned with general principles of care, kinesiology, soft tissue, and joint diseases. There is an interesting chapter on "ulnar drift" with a discussion of prevention and treatment by means of grafting and prosthetic replacement. One section is devoted to the thumb, the importance of which (as expressed by the author) represents 40 to 50 per cent of the function of the hand. Non-operative treatment is discussed and the book ends with a review of results.

The photographs are excellent as are the drawings and reproductions of x-rays. The book is well indexed and has five solid pages of references.

Dr. Flatt writes well and with conviction. Here, for instance is a discussion of the role of the diseased synovial membrane. "Rheumatoid disease transforms the thin lining membrane into an aggressive expanding tumor-like mass of tissue that is capable of penetrating tendon, ligaments, or bone and destroying articular cartilage."

Some of Dr. Flatt's ideas are at variance with those generally accepted, such as the recommendation for fusion of the wrist in neutral position or moderate flexion instead of 20 degree extension as is generally practiced and as recommended by Bunnell. He also states an elevated sedimentation rate is no contraindiction to surgery.

This reviewer briefly examined the 1st edition published in 1963. Many of the illustrations and much of the material is the same but the second edition has a final chapter with review of results. This closes with the author's hope that Utopia may arrive and that early treatment may eliminate the need for prosthetic replacements in the severely damaged hand. But in the meantime he intends to continue his study and search.

This book is enjoyable and profitable reading. It should prove of value to any of us — general practitioners, surgeons, internists and orthopedists — who see and treat the ubiquitious rheumatoid hand. Its theme is early and proper treatment, surgical if necessary, before extensive damage takes place.

HUGH M. BABBITT, M.D.

How to Develop a Well Adjusted Personality. Phillip Polatin, M.D.; Ellen C. Philtine. New York, 1968, Simon and Schuster. Pp. 150. (Paperback—$1.50)

It seems too bad that Dr. and Mrs. Polatin permitted the publisher to adopt as "common" a title as "How to . . .". A serious reader is likely to dismiss the book as one more of the "How to . . ." series. This would be unfair to the authors who have actually produced a smoothly written, readable, and useful little monograph. This is a condensation of their widely hailed *Well Adjusted Personality* first published a decade ago. The authors touch on every day problems in marriage, vocational adjustments, school, parent-child relationships, college life, and the major personality types. Dr. and Mrs. Polatin write in a jargon-free vein, yet never talk down to their readers. The material is a valuable source book for a psychologist, social worker, or psychiatrist preparing a public address and a comfortable guidebook for adults who have to wend their way through an emotional jungle.

HENRY A. DAVIDSON, M.D.

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Grinszpan, Goldstein and Divito[2] used Lomotil in 20 children with diarrhea and also reported a prompt disappearance of diarrhea. Harris and Beveridge[3] in a double-blind study of 50 children with diarrhea, however, found no clear pattern to suggest that Lomotil influenced the course of the condition.

Michener, Brown and Turnbull[4] added evidence supporting the beneficial effects of Lomotil in 80 children, concluding that Lomotil was highly useful in controlling abdominal cramping, diarrhea and hypermotility.

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ults: . . . . 2 tsp. 5 times daily (20 mg.) or 2 tablets q.i.d.

ed on 4 cc. per teaspoonful.

aintenance dosage may be as low one-fourth the initial daily dosage.

References:

1. Senra del Valle, A.; Linfante de Rufinelli, E. B.; Brumetti, E., and Rossi, R. H.: El chlorhidrato de difenoxilato en las diarreas infantiles, Sem. Med. (Buenos Aires) *127*:475-484 (Oct. 4) 1965. **2.** Grinszpan, I. L.; Goldstein, A., and Divito, J.: El chlorhidrato de difenoxilato en las diarreas infantiles, Sem. Med. (Buenos Aires) *125*:758-763 (Aug. 27) 1964. **3.** Harris, M. J., and Beveridge, J.: Diphenoxylate in the Treatment of Acute Gastro-Enteritis in Children, Med. J. Australia 2:921-922 (Nov. 27) 1965. **4.** Michener, W. M.; Brown, C. H., and Turnbull, R. B., Jr.: Ulcerative Colitis in Children. II. Medical and Surgical Therapy, Amer. J. Dis. Child. *108*:236-242 (Sept.) 1964.

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Just one tablet at bedtime • Prevents painful night leg cramps • Permits restful sleep

How many of your patients stamp their feet at night and lose sleep because of painful leg cramps? Unless prompted, they usually fail to report this distressing condition and suffer needlessly.

One tablet of QUINAMM at bedtime usually controls distressing night cramps and permits restful sleep with the initial dose.

Prescribing information—Composition: Each white, beveled, compressed tablet contains: Quinine sulfate, 260 mg., Aminophylline, 195 mg. **Indications:** For the prevention and treatment of nocturnal and recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis and static foot deformities. **Contraindications:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Side Effects/Precautions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144



Ornade®

Prompt relief from nasal congestion and hypersecretion due to colds.

Before prescribing, see complete prescribing information in SK&F literature or *PDR*.
Contraindications: Glaucoma, prostatic hypertrophy, stenosing peptic ulcer, pyloroduodenal or bladder neck obstruction.
Precautions: Use cautiously in the presence of hypertension, hyperthyroidism, coronary artery disease; warn vehicle or machine operators of possible drowsiness.
Usage in Pregnancy: Use in pregnancy, nursing mothers and women who might bear children only when potential benefits have been weighed against possible hazards.
Note: The iodine in isopropamide iodide may alter PBI test results and will suppress I^{131} uptake; discontinue 'Ornade' one week before these tests.
Adverse Reactions: Drowsiness; excessive dryness of nose, throat or mouth; nervousness; insomnia. Other known possible adverse reactions of the individual ingredients: nausea, vomiting, diarrhea, rash, dizziness, fatigue, tightness of chest, abdominal pain, irritability, tachycardia, headache, incoordination, tremor, difficulty in urination. Thrombocytopenia, leukopenia and convulsions have been reported.
Supplied: Bottles of 50 capsules.

One capsule q12h for round-the-clock relief

Ornade® Trademark. Each capsule contains 8 mg. of Teldrin® (brand of chlorpheniramine maleate); 50 mg. of phenylpropanolamine hydrochloride; 2.5 mg. of isopropamide, as the iodide.

Spansule® capsules

brand of sustained release capsules

Smith Kline & French Laboratories SK&F

Pertofrane®, desipramine hydrochloride
Indications: For relief of depression.
Contraindications: Do not use drugs of the M.A.O.I. class with Pertofrane. Hyperpyretic crises or severe convulsive seizures may occur; potentiation of adverse effects can be serious or even fatal. When substituting this drug in patients receiving an M.A.O.I., allow an interval of at least 7 days. Initial dosage in such patients should be low and increases should be gradual and cautiously prescribed.
Warning: Activation of psychosis may occasionally be observed in schizophrenic patients. Do not use in patients under 12 years old, and do not use in women who are or may become pregnant unless the clinical situation warrants the potential risk.
Precautions: Careful supervision and protective measures for potentially suicidal patients are necessary. Discontinuation of therapy or adjunctive use of a sedative or tranquilizer may be necessary in the presence of increased anxiety or agitation, hypomania or manic excitement. However, phenothiazines may aggravate the condition. Atropine-like effects may be more pronounced (e.g. paralytic ileus) in susceptible patients and in those receiving anticholinergic drugs (including antiparkinsonism agents). Carefully observe patients with increased intraocular pressure. Prescribe cautiously in hyperthyroid patients and in those receiving thyroid medications. Cardiovascular complications (myocardial infarction and arrhythmias) are potential risks since they have occasionally occurred with imipramine, the parent compound. Desipramine may bloc the pharmacologic activity of guanethidine and related adrenerg neuron-blocking agents. Hypertensive episodes have been obser during surgery in patients on desipramine therapy.
Before prescribing the drug, the physician should be thoroughly familiar with prescribing informat with the literature, with all adverse reactions, with the diagnosis and management of depression, and v the relative merits of all measures

You decide who needs how muc

PRESCRIPT



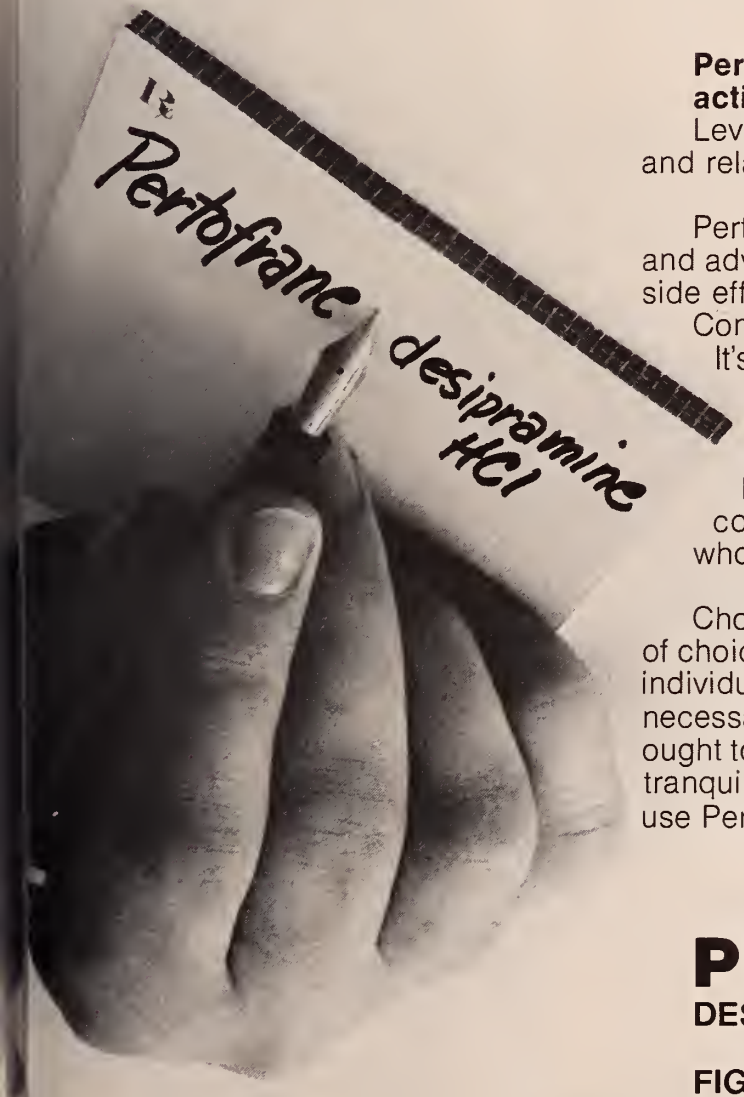
reating the condition.
Adverse Reactions: Dry mouth, onstipation, disturbed visual accommodation, anorexia, perspiration, insomnia, drowsiness, dizziess, headache, nausea, epigastric istress, and skin rash (including hotosensitization) may appear. ince orthostatic hypotension has ccurred, carefully observe patients equiring concomitant vasodilating herapy, particularly during the itial phases. Other adverse rections include tachycardia, changes in EEG patterns, tremor, falling, mild extrapyramidal activity, neuromuscular incoordination, epileptiform seizures. A confusional state (with such symptoms as hallucinations and disorientation) occurs occasionally and may require reduced dosage or discontinuance of therapy. Rarely, transient eosinophilia, slight elevation in transaminase levels, transient jaundice, or liver damage have occurred. If abnormalities occur in liver function tests, discontinue drug and investigate. Occasional hormonal effects, particularly decreased libido or impotence and instances of gynecomastia, galactorrhea and female breast enlargement have been observed. Urinary frequency or retention may occur. The drug should be discontinued if agranulocytosis, bone marrow depression, jaundice, thrombocytopenia, or purpura occur.
Dosage: 25 to 50 mg. t.i.d. The maximum daily dose is 200 mg. Continue maintenance dosage for at least 2 months after obtaining satisfactory response. Generally, elderly and adolescent patients should be given low doses.
Availability: Pink capsules of 25 mg. in bottles of 100 and 1000.
(B) 46-530-E

For complete details, please see the full prescribing information.

Geigy Pharmaceuticals
Division of
Geigy Chemical Corporation
Ardsley, New York 10502

antidepressant and how much tranquilizer—

ON POWER



Pertofrane can give rapid antidepressant action often within 3 to 5 days.
Levels of psychomotor activity, patient outlook and related somatic complaints may improve.

Pertofrane is well tolerated by most patients and adverse reactions are usually mild. A few serious side effects have been reported infrequently.
Consult full prescribing information before using. It's summarized above.

Anxious Depressives...
May require adjunctive use of tranquilizers; but they don't always fit ready-made drug combinations. Isn't it better for *you* to decide who needs how much of which drugs?

Choose Pertofrane and pick your tranquilizer of choice. With this "combination", control the individual drug dosage adjustments that may be necessary for proper therapy. Isn't that the way it ought to be? Please remember, phenothiazine tranquilizers may aggravate depression, and never use Pertofrane with an MAO inhibitor.

PERTOFRANE®
DESIPRAMINE HYDROCHLORIDE **Geigy**

FIGHTS DEPRESSION

DIARRHEA

TROCINATE

BRAND THIPHENAMIL HCl

The first 400 mg. Trocinate tablet usually relieves discomfort so promptly that Diarrhea ceases to be a bother

Trocinate has no known therapeutic value other than relaxing smooth muscle by direct action when coming in contact with the spastic muscle cell. Trocinate has none of the troublesome side-effects of anticholinergic drugs. Trocinate relieves the discomfort of diarrhea by decreasing both peristalsis and muscle tone. Trocinate is metabolized by the body and eliminated in the urine as harmless degradation products. Normal intestinal function is resumed.

The action of Trocinate is prompt, making the spacing of dosage easy. Often one or two 400 mg. tablets are sufficient to control diarrhea. The recommended dosage in spasm of the G. I. and G. U. tract is 400 mg. q. 4 h. A prescription of twelve (12) 400 mg. tablets will, in most cases, allow the patient to have a few to keep in reserve.

Literature and samples available

WILLIAM P. POYTHRESS & CO., INC.
RICHMOND, VIRGINIA 23217

Manufacturers of ethical pharmaceuticals since 1856

TROCINATE®

BRAND THIPHENAMIL HCl

DIARRHEA

ACHROMYCIN® V
TETRACYCLINE

Contraindications: Hypersensitivity to tetracycline.

Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.

Precautions: Nonsusceptible organisms may overgrow; treat superinfection appropriately. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Side Effects: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity reactions*—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

Upon adverse reaction, stop medication and treat appropriately.

Lederle

LEDERLE LABORATORIES
A Division of
American Cyanamid Company
Pearl River, New York 10965

359-8

Suspected tetracycline-sensitive infection?

While waiting for the results of the sensitivity test, start the therapy likely to succeed...

Although of course it can't replace routine sensitivity testing, your prescription for ACHROMYCIN® V, in a way, provides the ultimate test of therapy under rigorous *in vivo* conditions.

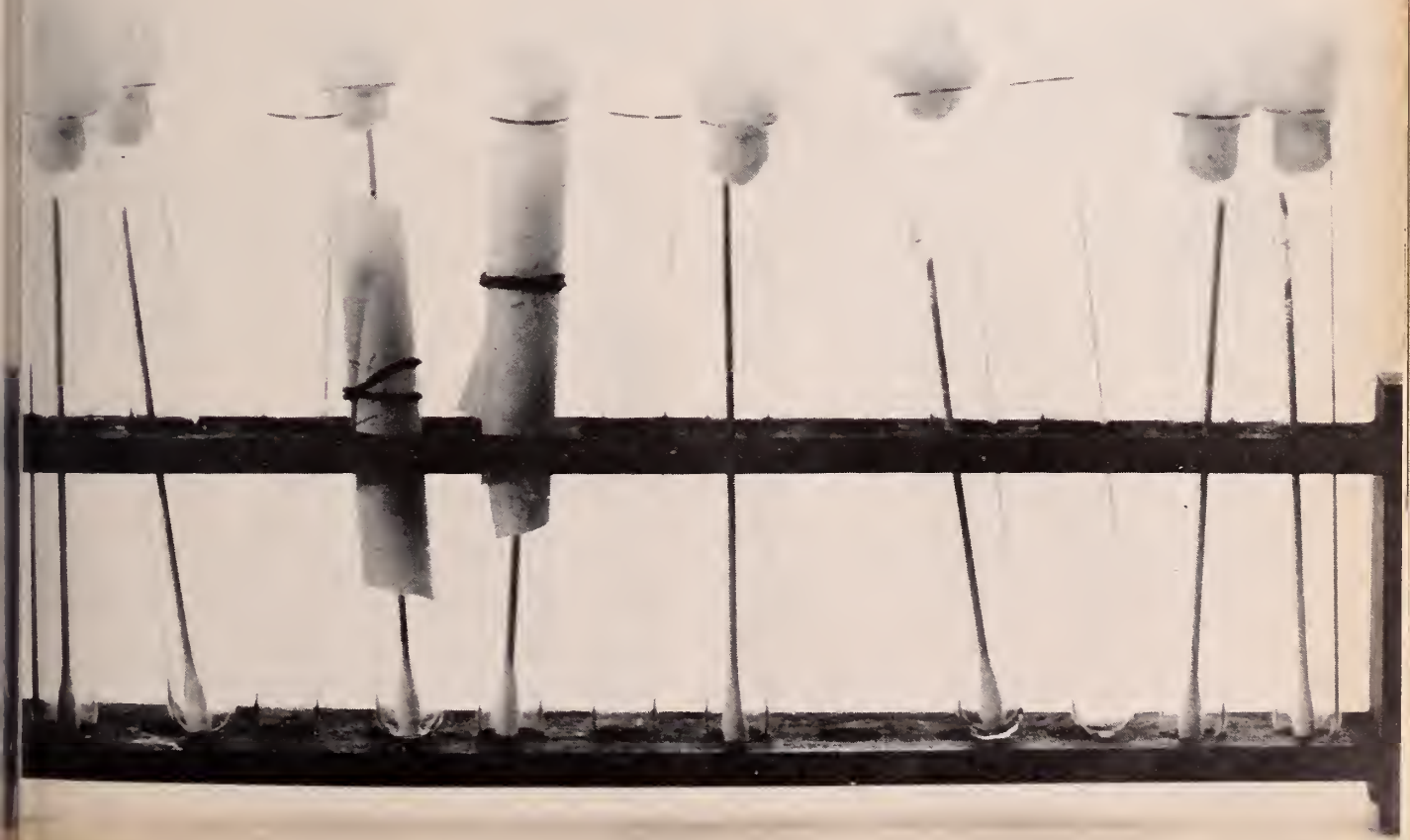
Because ACHROMYCIN® V is effective in treating so many common infections—caused by strains of tetracycline-sensitive organisms—doesn't *stat* dosage of this time-tested antibiotic make good sense?

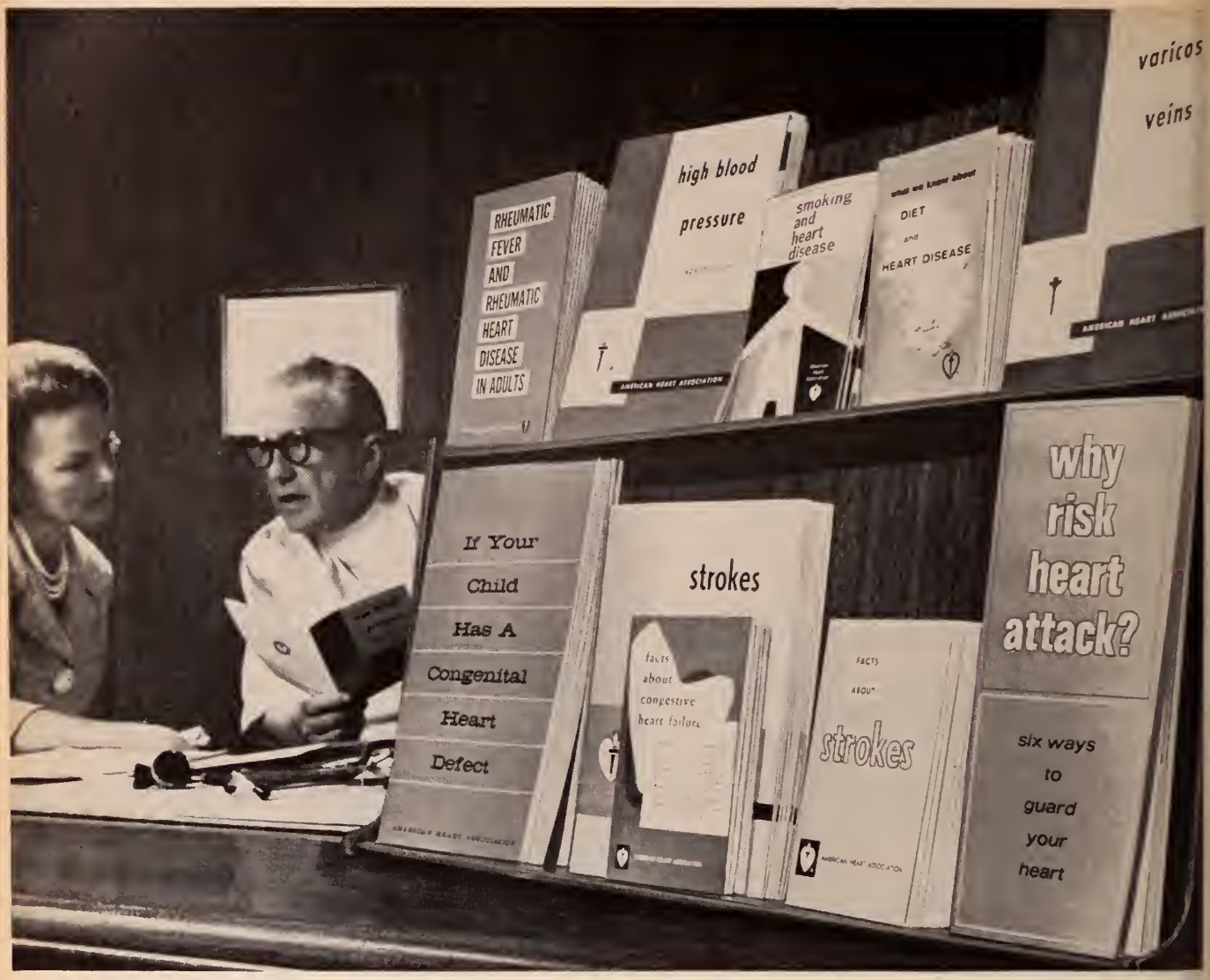
←Prescribing Information

ACHROMYCIN® V
TETRACYCLINE

Lederle

The price differential is inconsequential.





Your Heart Association can help you help your patients

Your patients and their families might have questions about the heart and blood vessel diseases. Your Heart Association has prepared a variety of pamphlets to assist you in answering their questions in simple non-technical language.

Produced under the guidance of leading cardiovascular specialists, these pamphlets deal with such subjects as heart attack, stroke, hypertension, rheumatic fever, congestive failure, inborn heart defects, varicose veins and other disorders. There are also pamphlets advising on risk factors related to heart attack, including persuasive arguments against cigarette smoking, and a fat-controlled, low-cholesterol diet plan for the general public. Booklets on therapeutic sodium-restricted or cholesterol-lowering diets are also available on a physician's prescription only.

Ask your local Heart Association for a catalogue listing all these free materials and order a supply.

American Heart Association®

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Maybe you owe money to banks, stores, companies or people.

We're in debt to wars, floods, health services, life saving and blood banks.

help
us
help

The American Red Cross.

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"Man's best friend" in wintertime diarrheas

In winter "flu" and viral gastroenteritis, Donnagel (4 oz. size!) can bring aid and comfort to sufferers from both diarrhea and its discomforts because it contains kaolin and pectin plus belladonna alkaloids (as in Donnatal®). Donnagel treats the whole diarrhea problem. Available on your prescription or recommendation. A. H. Robins Company, Richmond, Va. 23220

A·H·ROBINS

CLEAR THE TRACT! ROBITUSSIN



THERE'S A FORMULATION FOR EVERY COUGHING NEED

All five members of the Robitussin family contain glyceryl guaiacolate. This outstanding expectorant agent increases the output of lower respiratory tract fluid (R.T.F.) Increased R.T.F. volume thins mucus, thereby improving the action of bronchial and tracheal cilia and making thick, inspissated mucus less viscid and easier to raise.

For coughs of colds and "flu"

ROBITUSSIN®
Each 5 cc. contains:
Glyceryl guaiacolate ..... 100 mg.
Alcohol, 3.5%

For unproductive, allergic coughs

ROBITUSSIN A-C® (exempt narcotic)
Each 5 cc. contains:
Glyceryl guaiacolate ..... 100 mg.
Pheniramine maleate ..... 7.5 mg.
Codeine phosphate ..... 10.0 mg.
(warning: may be habit forming)
Alcohol, 3.5%

Non-narcotic for 6-8 hour cough control

ROBITUSSIN-DM®
Each 5 cc. contains:
Glyceryl guaiacolate ..... 100 mg.
Dextromethorphan hydrobromide .. 15.0 mg.
Alcohol, 1.4%

Robitussin-DM in solid form for "coughs on the go"

COUGH CALMERS™
Each Cough Calmer contains:
Glyceryl guaiacolate ..... 50 mg.
Dextromethorphan hydrobromide .. 7.5 mg.

Clears sinuses and nasal stuffiness as it relieves cough

ROBITUSSIN-PE®
Each 5 cc. contains:
Glyceryl guaiacolate ..... 100 mg.
Phenylephrine hydrochloride ..... 10.0 mg.
Alcohol, 1.4%

	Robitussin	Robitussin A-C	Robitussin-DM	Cough Calmers	Robitussin-PE
Expectorant	●	●	●	●	●
Demulcent	●	●	●	●	●
Cough Suppressant		●	●	●	
Antihistamine		●			
Non-Narcotic	●		●	●	●
Long-Acting (6-8 Hours)			●	●	
Nasal, Sinus Decongestant					●

PHOTO BY VICTOR HAND

A. H. Robins Company, Richmond, Va. 23220

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on Investment Bonus
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Think safety belts
are confining?

Not half as confining
as wheelchairs.

What's your excuse?

Advertising contributed for the public good.

TRAFFIC SAFETY CAMPAIGN

in the treatment of

IMPOTENCE



Android®

(thyroid-androgen) TABLETS

Effectiveness confirmed by another double blind study*

1. SUMMARY

ANDROID	GOOD TO EXCELLENT 75%
PLACEBO	20%

2. Forty cases reported.
3. Cites synergism between androgen and thyroid.
4. No side effects in patients treated.
5. Alleviation of fatigue noted
6. Case histories on 4 patients.
7. Although psychotherapy still needed, role of chemotherapy cannot be disputed.

*"Sexual impotence treatment with methyl testosterone – thyroid (ANDROID) a double blind study" – Montesano, Evangelista: Clinical Medicine, April 1966.

CONTRAINDICATIONS—Methyl testosterone is not to be used in malignancy of reproductive organs in male, coronary heart disease. Thyroid is not to be used in heart disease, hypertension unless the metabolic rate is low.

Choice of 4 strengths

Android

Each yellow tablet contains:
Methyl Testosterone . . 2.5 mg.
Thyroid Ext. (1/6 gr.) . . 10 mg.
Glutamic Acid . . . . . 50 mg.
Thiamine HCL . . . . . 10 mg.
Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000.

Android-HP
HIGH POTENCY

Each red tablet contains:
Methyl Testosterone . . 5.0 mg.
Thyroid Ext. (½ gr.) . . . 30 mg.
Glutamic Acid . . . . . 50 mg.
Thiamine HCL . . . . . 10 mg.
Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000.

Android-X
EXTRA HIGH POTENCY

Each orange tablet contains:
Methyl Testosterone . 12.5 mg.
Thyroid Ext. (1 gr.) . . . 64 mg.
Glutamic Acid . . . . . 50 mg.
Thiamine HCL . . . . . 10 mg.
Dose: 1 or 2 tablets daily.
Available:
Bottles of 60, 500.

REFER TO PDR

Android-Plus
WITH HIGH POTENCY B-COMPLEX AND VITAMIN C

Each white tablet contains:
Methyl Testosterone . . 2.5 mg.
Thyroid Ext. (¼ gr.) . . . 15 mg.
Ascorbic Acid (Vit. C) . 250 mg.
Thiamine HCL . . . . . 25 mg.
Glutamic Acid . . . . . 100 mg.
Pyridoxine HCL . . . . . 5 mg.
Niacinamide . . . . . 75 mg.
Calcium Pantothenate . 10 mg.
Vitamin B-12 . . . . . 2.5 mcg.
Riboflavin . . . . . 5 mg.
Dose: 2 tablet twice daily.
Available: Bottles of 60, 500.

also available with ESTROGEN

Android-E

Each Tablet Contains:
Methyl Testosterone . . . . . 2.5 mg.
Ethinyl Estradiol . . . . . 0.02 mg.
Thyroid Ext. (1/6 gr.) . . . . . 10 mg.
Thiamine Hydrochloride . . . . 10 mg
Glutamic Acid . . . . . 50 mg

INDICATIONS: Advantage is taken of the anabolic action of ANDROID without its virilizing effect. Estrogen balances the androgen—only steroid effect remains. Geriatrics, post-operative and debilitating disease, osteoporosis **DOSE**. One tablet t.i.d. Female patients should have a rest period 5 to 7 days after 21 days of medication. **SIDE EFFECTS:** In the female, excessive dosage may produce virilizing effects of most androgens. hoarseness, hirsutism, enlarged clitoris. Symptoms can be avoided by keeping the dosage below 300 mg. of testosterone per month. **CONTRAINDICATIONS**. See Android. Ethinyl estradiol is not to be used in latent malignancy of reproductive organs or mammary glands.

Write for literature and samples:

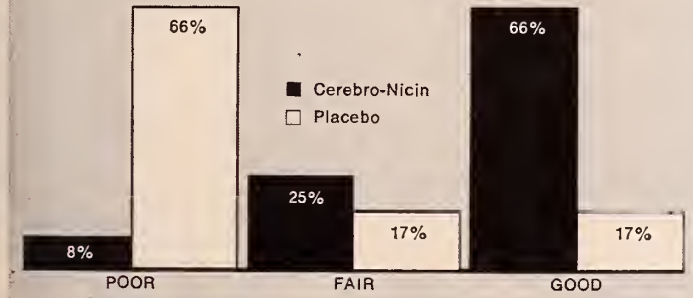
BROWN **THE BROWN PHARMACEUTICAL CO.**
2500 W. 6th St., Los Angeles, Calif. 90057

For the treatment of the aging patient

apathy
irritability
forgetfulness
confusion

Cerebro-Nicin® capsules/elixir

A Gentle Cerebral Stimulant and Vasodilator



CEREBRO-NICIN® New double-blind study* shows how effectively senility can be forestalled. Four times as many aging patients showed striking improvement.

*A Double-Blind Study of Cerebro-Nicin, Therapy for the Geriatric Patient, R. Goldberg Jrnl,. of the Amer. Ger. Soc. June, 1964

Available in a tasty wine base elixir and capsules

Each Cerebro-Nicin capsule contains:

Pentylenetetrazole . . . . . 100 mg.
Nicotinic Acid . . . . . 100 mg.
Ascorbic Acid . . . . . 100 mg.
Thiamine HCl . . . . . 25 mg.
l-Glutamic Acid . . . . . 50 mg.
Niacinamide . . . . . 5 mg.
Riboflavin . . . . . 2 mg.
Pyridoxine . . . . . 3 mg.

DOSAGE: One capsule t.i.d. or as prescribed by physician.
AVAILABLE: Bottles of 100, 500, 1000 capsules.
Also elixir pint bottles.
CONTRAINDICATIONS: There are no known contraindications to Pentylenetetrazole although caution should be exercised when treating patients with a low convulsive threshold.
Most persons experience a flushing or tingling sensation after taking a higher potency niacin-containing compound. As a secondary reaction some will complain of nausea and other sensations of discomfort. This reaction is transient and is rarely a cause of discontinuance of the drug if the patient is forewarned to expect the reaction.

REFER TO PDR

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when aging brings anguish

LEPTINOL®

Improvement of mental alertness and awareness in the management of the senility syndrome requires a comforting environment, a stimulating dietary regimen and concomitant drug therapy.

LEPTINOL® is a non-addictive stimulant which is a useful adjunct in elevating the mood of the elderly patient who displays apathy, mental confusion or memory lapses.

LEPTINOL® is a combination of pentylenetetrazol, niacin, thiamin and ascorbic acid which acts as a central nervous stimulant and which exerts its primary effect on the mid-brain and the medullary center. Because no addiction or intolerance is introduced, you may also find LEPTINOL® to be a welcome adjunct even to the treatment of slow degenerative diseases.

Each bi-layer tablet contains: Pentylenetetrazol 100 mg., Niacin 50 mg., Thiamine Hydrochloride 1 mg., Ascorbic Acid 20 mg. Dose—one or two tablets three times daily, one-half hour before meals. Maximum dosage is two tablets per dose, six tablets per day.

Side effects—Excessive dosage may cause transient flushing, muscular twitching, hyperreflexia and convulsions, and respiratory paralysis. Use cautiously in elderly patients who are unstable or paranoid.

Contraindicated in patients with low convulsive threshold, epilepsy or severe hypertension.

LEPTINOL® is supplied in bottles of 100, 500 and 1,000 tablets.

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Tuberculosis? Influenza?
Pneumonia? Leukemia?
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Systemic Fungal Diseases?
Chronic Chest Diseases?
or

HISTO?

(Histoplasmosis—"The Masquerader")



A new aid in differential diagnosis

HISTOPLASMIN, TINE TEST

(Rosenthal)

The LEDERTINE™ Applicator with the Blue Handle

Precautions—Nonspecific reactions are rare, but may occur. Vesiculation, ulceration or necrosis may occur at test site in highly sensitive persons. The test should be used with caution in patients known to be allergic to acacia, or to thimerosal (or other mercurial compounds).

Lederle

Ask your representative for details or write Medical Advisory Dept., Lederle Laboratories, Pearl River, New York 10965. 406-8



When she gets a bacterial infection, think of Tetrex-F®

Like the debilitated or diabetic patient, she may be susceptible to monilial overgrowth.

That's why she needs the extra protection of Tetrex-F whenever tetracycline therapy is indicated. Tetrex-F provides well-tolerated tetracycline phosphate complex for the bacterial infection—nystatin to help prevent monilial overgrowth.

Tetrex-F®

(tetracycline phosphate complex-nystatin)

Whenever monilia may threaten tetracycline therapy

PRESCRIBING INFORMATION. For complete information consult Official Package Circular. *Indications:* Infections of respiratory, gastrointestinal and genitourinary tracts and skin and soft tissues due to tetracycline-sensitive organisms, in patients with increased susceptibility to monilial infections. *Contraindications:* The drug is contraindicated in patients hypersensitive to its components. *Warnings:* Photodynamic reactions have been produced by tetracyclines. Natural and artificial sunlight should be avoided during therapy. Stop treatment if skin discomfort occurs. With renal impairment, systemic accumulation and hepatotoxicity may occur. In this situation, lower doses should be used. Tooth staining and enamel hypoplasia may be induced during tooth development (last trimester of pregnancy, neonatal period and childhood). *Precautions:* Bacterial superinfections may occur. Infants may develop increased intracranial pressure with bulging fontanels. In gonorrheal therapy, serologic tests for syphilis should be conducted initially and monthly for 3 months. *Adverse Reactions:* Glossitis, stomatitis, nausea, diarrhea, flatulence, proctitis, vaginitis, dermatitis, and allergic reactions may occur. *Usual Adult Dosage:* 1 capsule q.i.d. Continue for 10 days in Beta-hemolytic streptococcal infections. Administer one hour before or two hours after meals. *Supplied:* Capsules, bottles of 16 and 100. Each capsule contains tetracycline phosphate complex equivalent to 250 mg. tetracycline HCl activity and 250,000 units of nystatin. For Oral Suspension, 125 mg. tetracycline and 125,000 u. nystatin/5 ml., 60 ml. bottles. **A.H.F.S. Category 8:12**

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Division of Bristol-Myers Co.
Syracuse, New York 13201

State of New Jersey

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First, second, and third year level in a three year training program approved by the AMA Council on Medical Education in a J.C.A.H. accredited 4200 bed sectionalized psychiatric hospital, easily accessible to New York City. Comprehensive dynamically oriented training in adult, adolescent, and child psychiatry with excellent instruction in basic and clinical neurology. Intensive preceptor supervision. Experience in individual, group and organic therapy, out-patient after care service, affiliation in child psychiatry and psychosomatic medicine, didactic lectures by prominent medical school faculty. Attendance at psychiatric meetings encouraged. Excellent staff opportunities on successful completion of training. Stipend from $9500 to $11,500. Some living facilities available. Contact Dr. Archie Crandell, Medical Director, N. J. State Hospital, Greystone Park, New Jersey 07950. Vacancies also exist at other State Institutions in New Jersey. For information contact Robert E. Adams, M.D., Deputy Director, Division of Mental Health and Hospitals, 135 West Hanover Street, Trenton, N. J. 08625. Phone: (609) 292-5131.

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NEW JERSEY–BOARD CERTIFIED OR BOARD ELIGIBLE PHYSICIANS; to plan now and later direct medical programs of broad scope; new ultra-modern institution for approximately 800 mentally retarded with 100 bed medical and surgical hospital; beautiful location in semirural rolling lake country near Clinton on route 22, 40 miles equidistant New York and Philadelphia, close to Hunterdon Medical Center; salary from $22,000; 35 hour work week (which offers opportunity for limited outside practice); medical; free insurance of 1 & ½ times the annual salary; and retirement benefits; 1 month vacation plus 12 holidays; sick leave (15 days a year). For further information contact **A. C. Sootkoos, Superintendent, Hunterdon State School, Box 5220, Clinton, New Jersey 08809. Telephone: (201) 735-4031.**

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Dear Doctor:

A word about consultations

Consultations make an important contribution to quality medical care. Medical-Surgical Plan paid more than one million dollars for them last year. However, since the Plan has been receiving an increasing number of claims for unnecessary or ineligible consultations, an inquiry was made to the Judicial Council of the American Medical Association and we received from the Council the following statement of policy on consultations:

> "A physician should not charge a fee for services he does not personally perform. In addition, the Council said that charges which unnecessarily increase the cost of medical care are unethical. Among these charges are those made for unnecessary or excessive consultations conducted by a physician on the same service, in the same office, or in the same speciality as the attending physician. Charges for consultation of this nature are to be avoided. A charge normally should not be made for consultation required by hospital rules and regulations."

In view of the above statement of the Judicial Council the Plan would like to restate the criteria for eligible consultations.

An ELIGIBLE consultation must:

- Be rendered at the request of the attending physician
- Include a personal examination of the patient by the consultant
- Include a notation on the patient's hospital chart of the findings and recommendations of the consultant

----and not fall under either of the following categories, which are INELIGIBLE for Plan payment:

- Mandatory consultations performed solely because of hospital staff regulations
- Routine preoperative clearances

And finally, because of the recent opinion of the Judicial Council stated above, the Plan shall not pay for consultation by partners or by specialists in the same field of medicine except in most unusual cases.

The vast majority of the medical profession already follow the above criteria for consultations and we are sure that they will all agree that it is the duty of the Plan not to pay for unnecessary consultations which are unethical, and which increase the cost of medical care.

Thanking you for your cooperation,

Sincerely,

Joseph P. Donnelly M.D.

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Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma.
Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms have occurred following abrupt discontinuance. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.
Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.
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MARCH 1969
VOL. 66, No. 3

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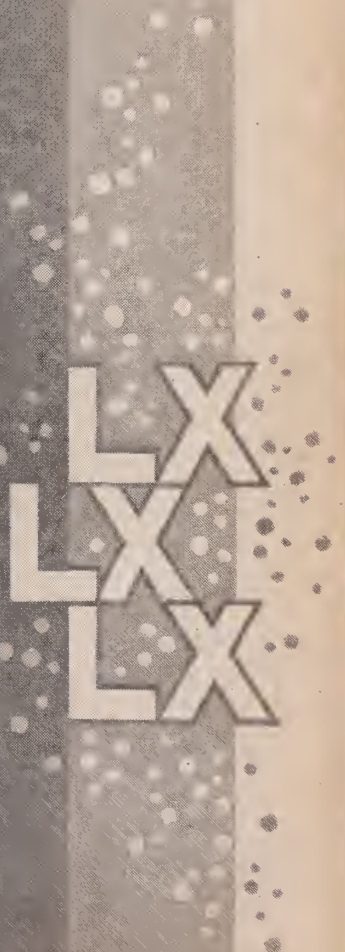
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(1) Siver, R. H.: CMD, *21*:109, September 1954. (2) Frykman, H. H.: Minn. Med., *38*:19-27, January 1955. (3) McGivney, J.: Tex. State Jour. Med., *51*:16-18, January 1955. (4) Quehl, T. M.: Jour. of Florida Acad. Gen. Prac., *15*:15-16, October 1965. (5) Weekes, D. J.: N.Y. State Jour. Med., *58*:2672-2673, August 1958. (6) Weekes, D. J.: EENT Digest, *25*:47-59, December 1963. (7) Abbott, P. L.: Jour. Oral Surg., Anes., & Hosp. Dental Serv., 310-312, July 1961. (8) Rapoport, L. and Levine, W. I.: Oral Surg., Oral Med. & Oral Path., *20*:591-593, November 1965.

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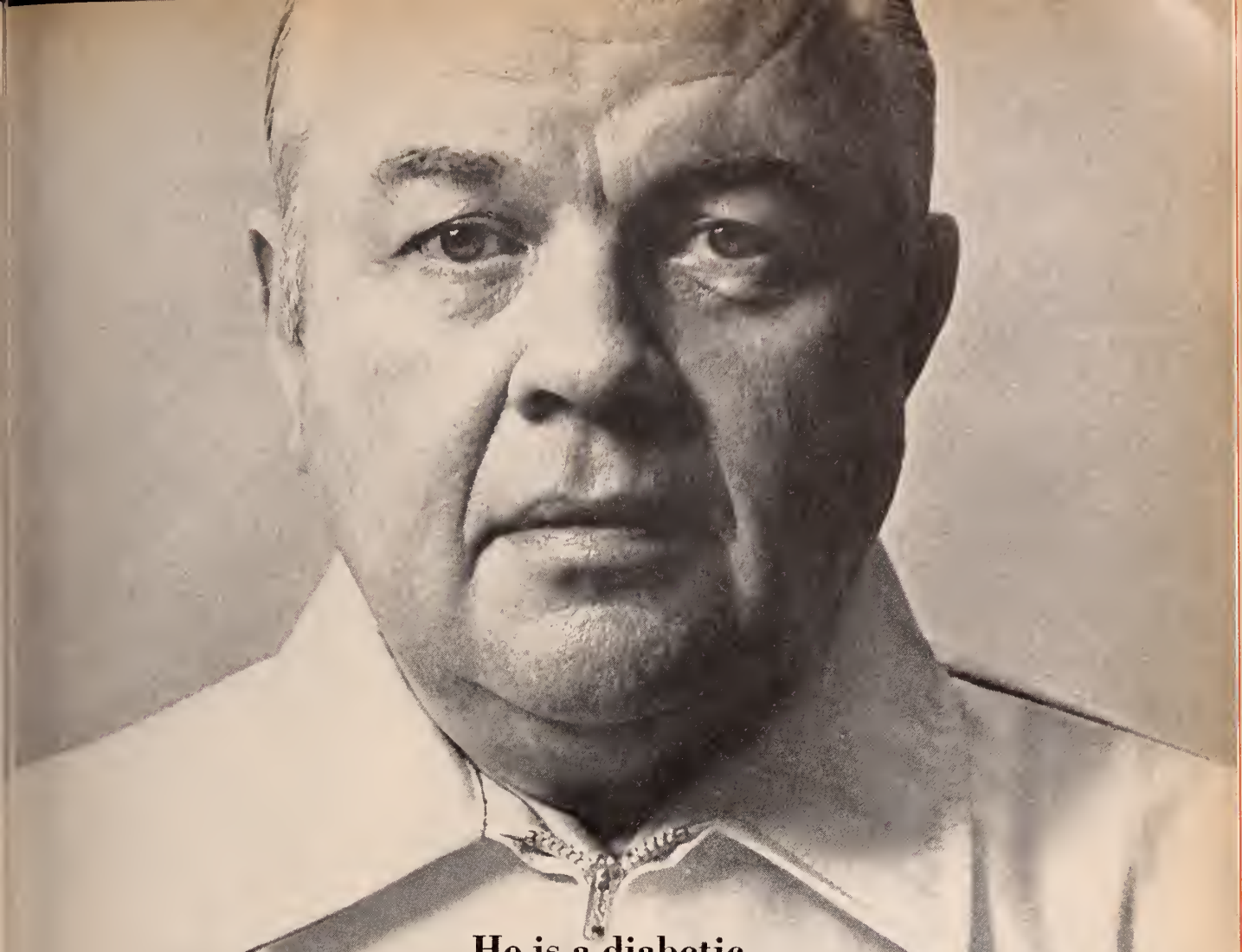
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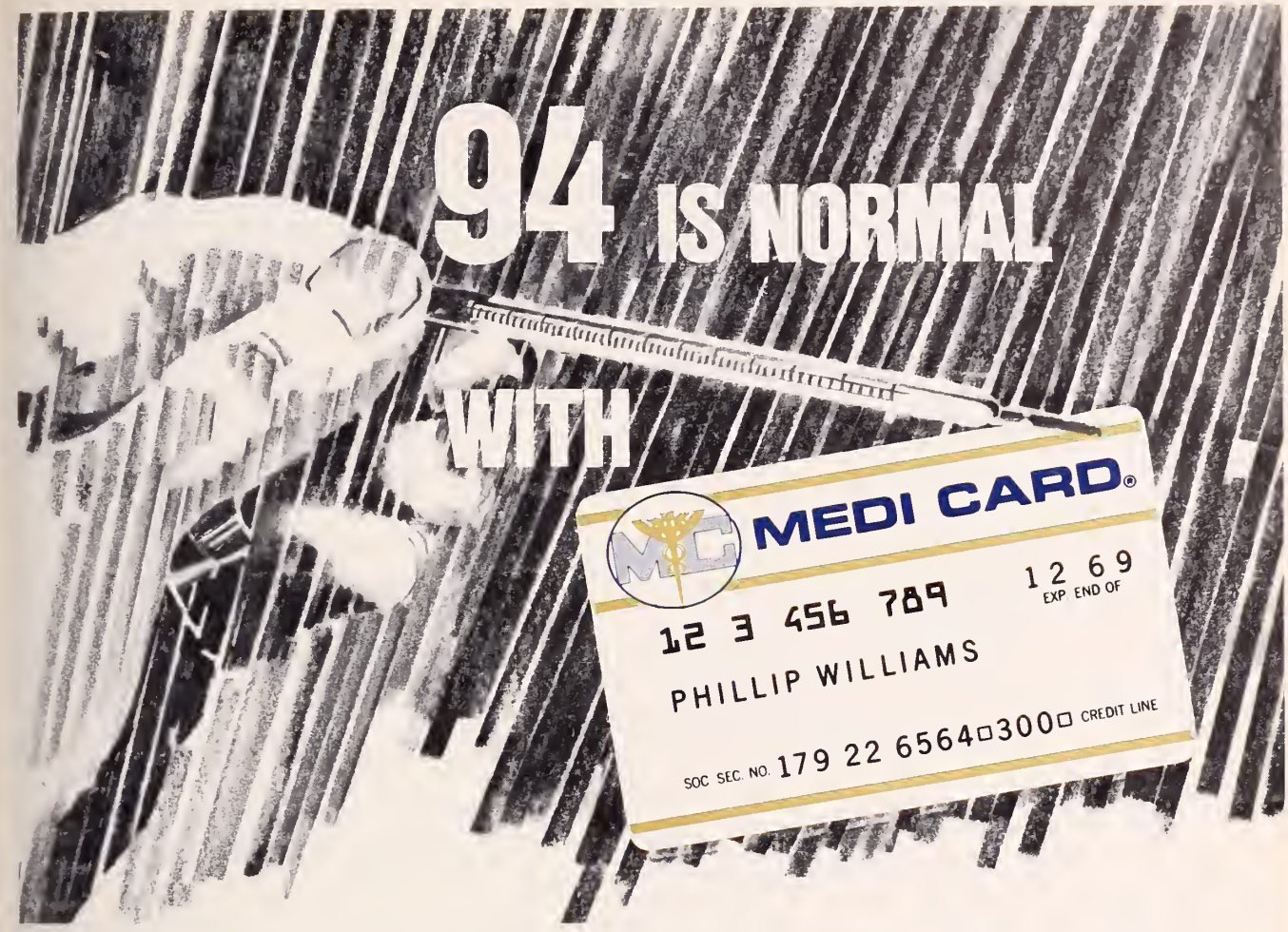
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Q. Can Medi Card now take over my patients' accounts receivable?

A. Medi Card cannot take over your patients' accounts receivable at this time but will process all patient applications received from you without charge.

Q. Do you make an individual credit check on each one of my patients?

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Q. Are patient application forms readily available?

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A. Medi Card may be used by any member of the family providing the card holder signs the Medi Card draft.

Q. What about Medi Card's financial responsibility?

A. Medi Card, a publicly held corporation, is associated in this program with Financial Services, Inc., a wholly owned subsidiary of the Diners Club.

Q. How much paperwork is involved?

A. The Medi Card draft is the simplest form ever devised for the payment of professional fees and services. Only two lines of the draft have been allotted for briefly outlining treatment. It is as fast as writing a personal check.

Q. Is there recourse to me in the event the patient does not pay Medi Card?

A. There is no recourse whatsoever. All the collection responsibility lies with Medi Card thus freeing you to maintain a professional relationship with your patient.

Q. Under what conditions will Medi Card refuse to pay a draft?

A. (1) Where the charge is incurred after the expiration date shown on the card. (2) Failure to fill out and mail processing card to us before, or along with, first draft.

Q. How much of my bill will Medi Card pay?

A. Medi Card will pay you up to the amount of credit shown on the face of the card, less the service charge.

Q. How does Medi Card protect the cardholder?

A. (1) Medi Card protects the cardholder by providing funds for professional services in amounts from $100 to $5,000 when they are needed. (2) Medi Card further protects the cardholder and his family by providing a 24-hour nationwide emergency medical information service making personal medical information available immediately through the use of a Medi Card toll-free telephone credit call. (3) In addition, this service provides all necessary professional payment information to the caller.

Q. How will I know each individual patient's Credit Limit?

A. Each patient's Credit Limit is clearly shown on the face of his Medi Card.

Q. Will you publish a list of professional participants?

A. No. Medi Card will not publish such a list because professional participants are not members of Medi Card.

What must I do to join Medi Card?

You do not join Medi Card so there is nothing to do — no membership forms or questionnaires to fill out. Medi Card provides you with a professional kit that comes without cost. Reorders of Medi Card drafts are also available free.

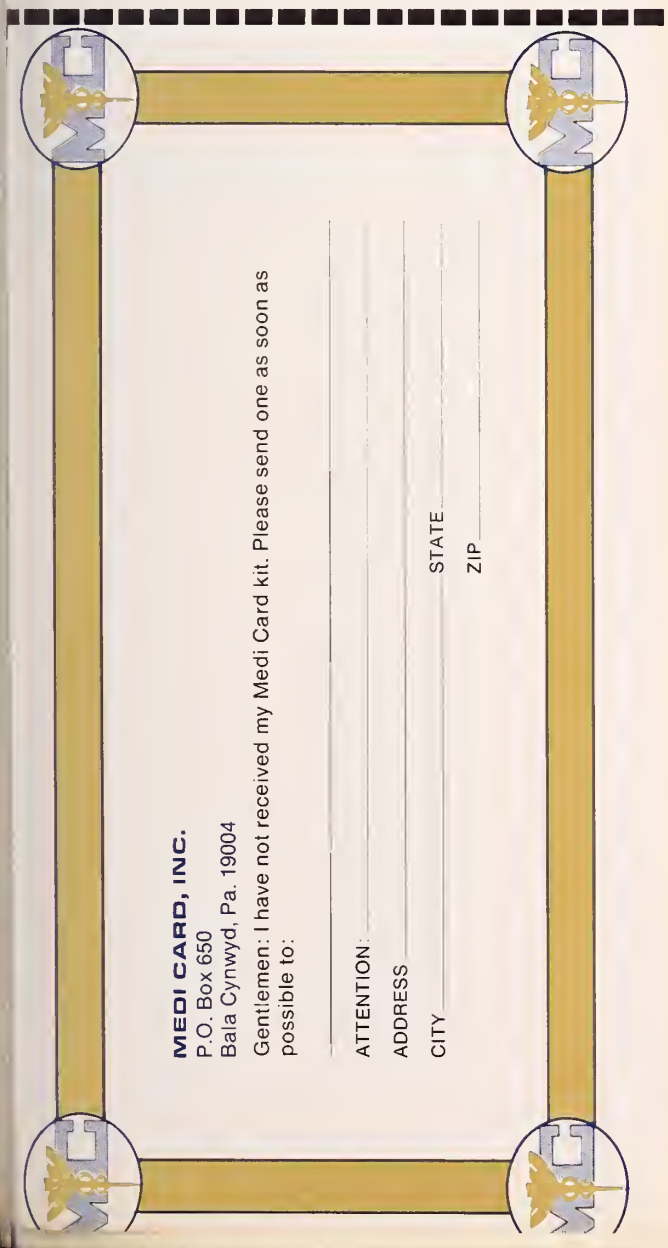
What is included in my professional Medi Card kit?

Your kit contains complete information and instructions on how Medi Card works, 100 drafts, a plaque stating you accept Medi Card and 200 application forms.

If my patient elects to use the extended payment plan, what are the service charges?

If a cardholder pays his Medi Card charge in full within 25 days, there is no service charge. If he elects to use the extended payment plan, Medi Card charges him 1½% per month on the unpaid balance, (or less, according to state legal rate). He may pay his balance at any time, during the extended payment period.

SEND FOR FREE KIT containing a supply of draft forms and complete details about Medi Card and how it helps both you and your patients. Use the handy pre-paid, pre-addressed card below, or write to Medi Card:



SEND FOR FREE KIT

containing a supply of draft forms and comple
details about Medi Card and how it helps both y
and your patients. Use the handy pre-paid pre-a
dressed card below, or write to Medi Card:

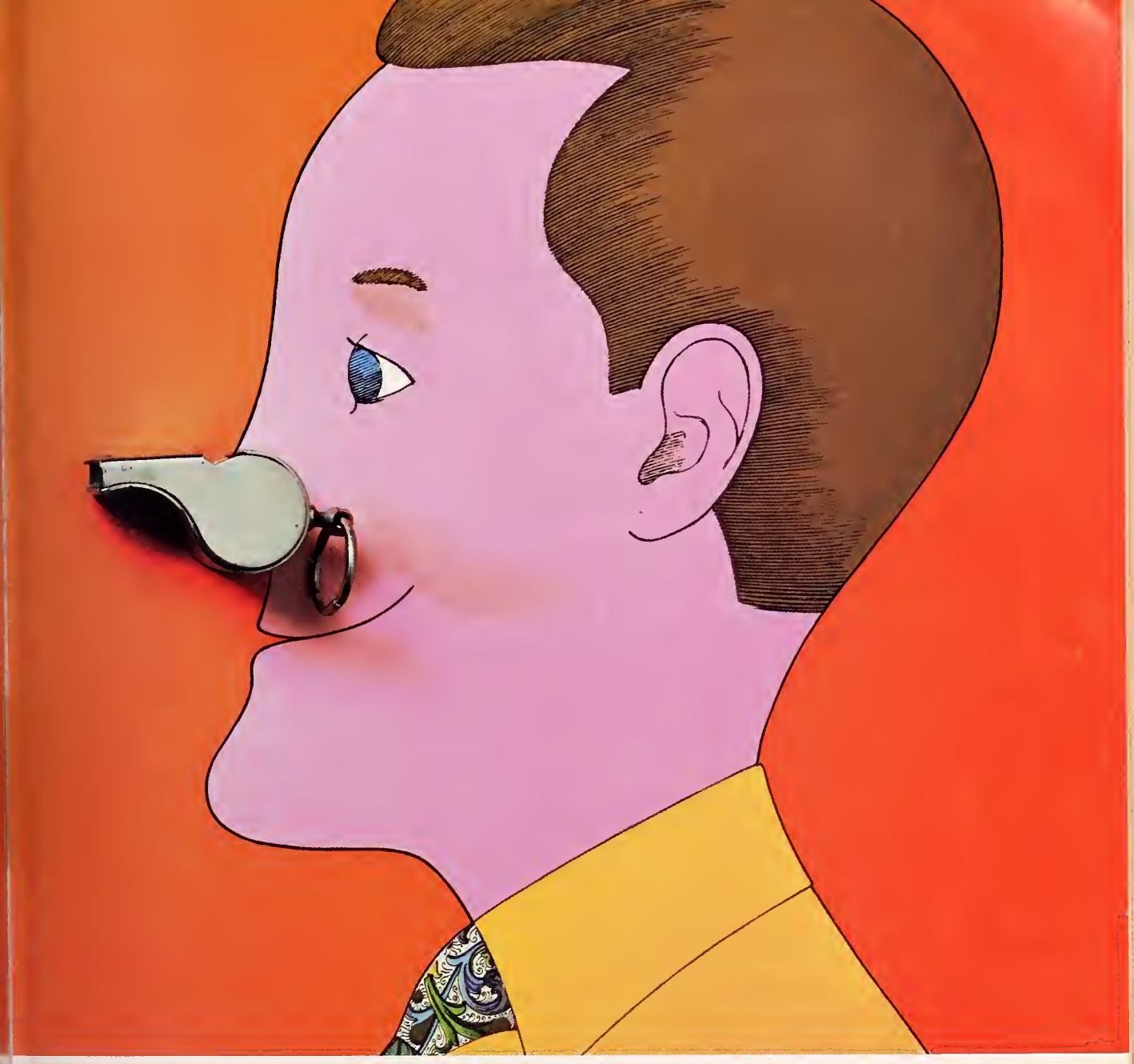
MEDI CARD, INC
P.O. Box 650
Bala Cynwyd, Pa. 19C

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PHILA., PA.

BUSINESS REPLY MAIL
NO POSTAGE STAMP NECESSARY IF MAILED IN THE UNITED STATES

Postage Will Be Paid By

MEDI CARD INC.
P.O. BOX 650
BALA CYNWYD, PA. 19004



Nose clear as a whistle

(THANKS TO DIMETAPP®)

Dimetapp Extentabs® does an outstanding job of helping to clear up the stuffiness, drip and congestion of colds and upper respiratory allergies and infections. Each Extentab keeps working up to 12 hours. And for most patients drowsiness or overstimulation is unlikely. Try Dimetapp. It clearly works.

FOR UPPER RESPIRATORY ALLERGIES AND INFECTIONS

Dimetapp Extentabs®

Dimetane® (brompheniramine maleate), 12 mg.; phenylephrine HCl, 15 mg.; phenylpropanolamine HCl, 15 mg.

UP TO 12 HOURS CLEAR BREATHING ON ONE TABLET

Indications: Dimetapp is indicated for symptomatic relief of the allergic manifestations of respiratory illnesses, such as the common cold and bronchial asthma, seasonal allergies, sinusitis, rhinitis, conjunctivitis, and otitis.
Contraindications: Hypersensitivity to antihistamines. Not recommended for use during pregnancy.
Precautions: Until patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care to patients with cardiac or peripheral vascular diseases or hypertension.
Side Effects: Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia, have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered.
Dosage: 1 Extentab morning and evening.
Supplied: Bottles of 100 and 500.

A.H. ROBINS COMPANY
RICHMOND, VA. 23220

A·H·ROBINS



Owner Breaks Arm When Yacht Runs Agroun

Schuyler, Oct. 31. Harry Waters of Covesville incurred a fractured arm [illegible] yacht [illegible] ck a large rock tially capsized. The fire depa had to rescue Waters by sma Damage to the yacht is estim 0.

Hasn't the skipper had enough excitement for one day?

For the patient who has been through an accident, the worry and anxiety following the mishap may actually heighten the perception of pain. This is why there's a classic ¼ grain *sedative* dose of phenobarbital in Phenaphen with Codeine—to take the nervous "edge" off, so the rest of the formula can control the pain more effectively.

A.H. Robins Company, Richmond, Va. 23220 A·H·ROBINS

Phenaphen® with Codeine

Phenaphen with Codeine Nos. 2, 3, or 4 contains: Phenobarbital (¼ gr.), 16.2 mg. (warning: may be habit forming); Aspirin (2½ gr.), 162.0 mg.; Phenacetin (3 gr.), 194.0 mg.; Hyoscyamine sulfate, 0.031 mg.; Codeine Phosphate, ¼ gr. (No. 2), ½ gr. (No. 3), or 1 gr. (No. 4) (warning: may be habit forming)

The compound analgesic that calms instead of caffeinates

Indications: Phenaphen with Codeine provides relief in severer grades of pain, on low codeine dosage, with minimal possibility of side effects. Its use frequently makes unnecessary the use of addicting narcotics. **Contraindications:** Hypersensitivity to any of the components. **Precautions:** As with all phenacetin-containing products excessive or prolonged use should be avoided. **Side effects:** Side effects are uncommon, although nausea, constipation and drowsiness may occur. **Dosage:** Phenaphen No. 2 and No. 3—1 or 2 capsules every 3 to 4 hours as needed; Phenaphen No. 4—1 capsule every 3 to 4 hours as needed. For further details see product literature.



ALKALINE....Aromatic Irrigant

"Therapeutically Sound and Scientifically Correct"



... In Feminine Hygiene

B&A®
HYGIENIC POWDER

"Early in 1953 Davis and Grand undertook a review of well established practices connected with the treatment of T. vaginalis infections. For instance, it had been accepted that an acid douche should be employed. This was based on cultural studies showing that when the pH was below 5 the organisms would die. They found that the commonly used vinegar douche with a pH of 3 showed no visible effect on T. vaginalis under the microscope in 15 minutes. Both citric and lactic acid were tested with similar results. Davis then recalled that in his early treatment of T. Vaginalis infections over 30 years ago he had had his first successes with alkaline preparations, and when he returned to their use the patients reported them more soothing than the previously used acid solutions."

(Am. J. Obst. & Gynec., 68:559, 1954)

Criteria for Cleansing Douche

"Daily douching often is a part of the treatment administered in dealing with T. vaginalis and since it is possible that the solution might contain agents that could hamper the regrowth of Doederlein bacillus, the following properties were said to be ideal.

1. It should contain a harmless, nonsensitizing detergent to remove mucous deposits and debris.
2. It should not contain any antibacterial agents, since the contact possible during douching would be so fleeting that anti-bacterial action could not be expected.
3. It should be acid in pH.

The 3rd property seems to be the most illogical and unimportant. If contact is so fleeting that antibacterial actions could not be expected, it would seem to follow that its acid quality would be of no consequence. Furthermore, acid solutions are irritating to the mucosa and oftentimes accentuate inflammation.

Actually, the value of a douche is generally conceded to be confined to its use as a cleansing and deodorizing agent. The encouraging results achieved with a detergent douche solution in treating infections of the vagina are probably attributable to the enormous normal recuperative powers of the vaginal tissues which have been under-estimated as a factor in the restoration of normal physiology.

Therefore, simple cleansing of the vagina with a non-irritating, mildly alkaline douche which is soothing to the vaginal mucosa and which penetrates and flushes out the dead organisms, debris and mucinous materials frequently enables the physiological processes to overcome the infection."

Charles B. Marek, M.D., Chief of Gynecology; Bon Secours Hospital: personal communications August 11, 1964

For physician samples write to:

ERL

Eastern Research Laboratories, Inc. • 302 S. Central Ave. • Baltimore, Md. 21202

no gag



DIA-QUEL actually tastes good

DIA-quel contains the only therapeutically active ingredient of paregoric—tincture of opium. This has been combined with homatropine methylbromide and pectin to make a sensible antidiarrheal formula.

By leaving out paregoric's outdated preservative—bitter-tasting camphor—we've produced an antidiarrheal that is good-tasting, as well as effective and prompt-acting in acute, nonspecific diarrheas and their accompanying "cramps." It is DIA-quel, a clear, red liquid with a pleasant cherry flavor.

Each teaspoonful (5 ml.) of DIA-quel Liquid contains:
Tincture of Opium... 0.03 ml.—Equivalent to 0.75 ml. of paregoric.
(Warning: May be habit forming)
To reduce hypermotility and frequency.
Homatropine Methylbromide... 0.15 mg.
A safe dose for mild spasmolysis to curb cramping and griping.
Pectin... 24. mg.
Demulcent, adsorbent. Helps form stools.
Alcohol 10% by volume.

In case you're curious, back in the 1700's paregoric was being used for diarrhea, but since the state of the pharmaceutical art was extremely primitive, fungus growth in the medication was a problem. Bitter-tasting camphor was added to prevent such growth and anise oil was added in an attempt to cover up the camphor taste. DIA-quel Liquid is a modern formulation that does not contain either of these outdated ingredients.

Caution: With use of DIA-quel Liquid observe the usual precautions associated with opium derivatives and anticholinergics.

Dosage: Usual adult dosage: 1 or 2 tablespoonfuls (15 or 30 ml.) t.i.d. or q.i.d. Usual children's dosage (Clark's rule): ½ to 2 teaspoonfuls (2.5 to 10 ml.) t.i.d. or q.i.d.

How Supplied: In 4 fl. oz. (118 ml.) band-sealed bottles.

DQ720918

DIA-quel is a Federally exempt narcotic (Class X) preparation. Where state law permits, no prescription is necessary.

For a complimentary sample of DIA-quel, simply mail your request to us on a signed prescription blank.

DIA-QUEL LIQUID

IPC
REG. U.S. PAT. OFF.

INTERNATIONAL PHARMACEUTICAL CORP.
Warrington, Pennsylvania 18976


It takes more than a pil
to lose weight

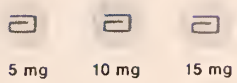
That's why Abbott's got what it takes–
a pill and a program for each patient

THE PRODUCT–5 Different Strengths

For smooth appetite control plus mood elevation

Desoxyn® Gradumet®

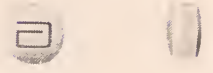
Methamphetamine Hydrochloride in Long-Release Dose Form



For patients who can't take plain amphetamine

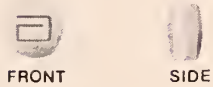
Desbutal® 10 Gradumet

10 mg. Methamphetamine Hydrochloride, 60 mg. Sodium Pentobarbital



Desbutal 15 Gradumet

15 mg. Methamphetamine Hydrochloride, 90 mg. Sodium Pentobarbital



THE PROGRAM–3 Patient Booklets



Weight Control Booklet

Specifically written to help your patients understand why they are overweight, and what they can do about it. The booklet stresses the importance of *changing lifelong eating habits* and explains how this can be done, sensibly, comfortably —and permanently. Food exchanges and a comprehensive list of foods, showing their calories, are also included.



Food Diary

Designed to help the overweight patient follow your eating instructions. Space is provided for breakfast, lunch, supper, and even snacks. By writing down everything that's eaten each day, the patient is constantly reminded that she's trying to change her eating habits. And you are furnished with a written record of how well she's doing.



Picture Menu Booklet

Compact new booklet features appetizing lunch and dinner menus for every day of the week. The meals are depicted in full color and the correct portion size so that the dieter can see the amount of food that's recommended. Patients are pleasantly surprised to learn that each day's meals add up to only 1,000 calories.

902110

ABBOTT

Please see Brief Summary on next page.

Ask Your Abbott Man For Patient Supplies.

BRIEF SUMMARY

Desoxyn® Gradumet®

Methamphetamine Hydrochloride
in Long-Release Dose Form

Desbutal® 10 Gradumet

10 mg. Methamphetamine Hydrochloride,
60 mg. Sodium Pentobarbital

Desbutal 15 Gradumet

15 mg. Methamphetamine Hydrochloride,
90 mg. Sodium Pentobarbital

Indications: Desoxyn and Desbutal are used orally as appetite suppressants, for reduction of mild mental depression, and to help in management of psychosomatic complaints or neuroses. Desoxyn, when administered parenterally, may be used as a vasopressor agent or analeptic.

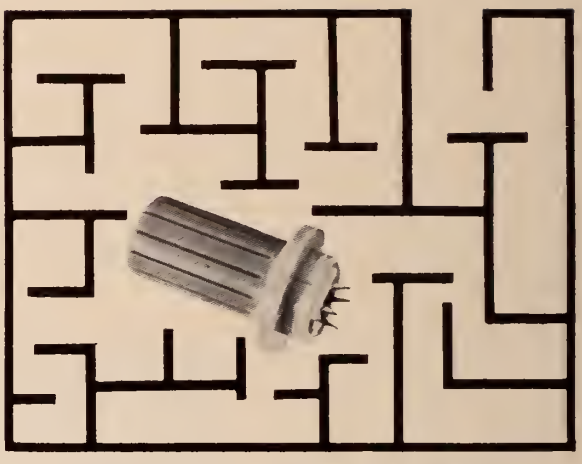
Contraindications: Methamphetamine (in Desoxyn and Desbutal) is contraindicated in patients taking a monoamine oxidase inhibitor. Do not use pentobarbital (in Desbutal) in persons hypersensitive to barbiturates, or in those with history of manifest or latent porphyria.

Precautions, Side Effects: Observe caution in patients with hypertension, cardiovascular disease, hyperthyroidism, old age, or those sensitive to sympathomimetic drugs. Prolonged usage may lead to tolerance or psychic dependence. Careful supervision is necessary to avoid chronic intoxication and drug dependence.

Amphetamine side effects such as headache, excitement, agitation, palpitation or cardiac arrhythmia usually may be controlled by reducing the dose. Paradoxically-induced depression is an indication to withdraw the drug. Because of its sodium pentobarbital content, use Desbutal with caution in patients receiving coumarin anticoagulants. Pentobarbital may cause skin rash. Nervousness or excessive sedation with Desbutal is often transient.

902110

ABBOTT



HISTO IS CONFUSING.

Histoplasmosis can mimic such unrelated diseases as TB, leukemia, pneumonia and syphilis. Use the blue Histoplasmin LEDERTINE™ Applicator as the first step in differential diagnosis and as a routine step in physical examinations for the permanent records of your patients.

HISTOPLASMIN, TINE TEST
(Rosenthal)

Precautions—Nonspecific reactions are rare, but may occur. Vesiculation, ulceration or necrosis may occur at test site in highly sensitive persons. The test should be used with caution in patients known to be allergic to acacia, or to thimerosal (or other mercurial compounds).

Lederle LEDERLE LABORATORIES
A Division of American Cyanamid Company, Pearl River, New York
473-9



When she gets a bacterial infection, think of Tetrex-F®

Like the debilitated or diabetic patient, she may be susceptible to monilial overgrowth.

That's why she needs the extra protection of Tetrex-F whenever tetracycline therapy is indicated. Tetrex-F provides well-tolerated tetracycline phosphate complex for the bacterial infection—nystatin to help prevent monilial overgrowth.

Tetrex-F®

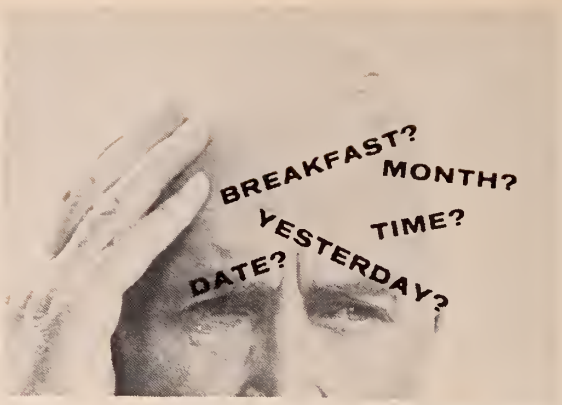
(tetracycline phosphate complex-nystatin)

Whenever monilia may threaten tetracycline therapy

PRESCRIBING INFORMATION. For complete information consult Official Package Circular. *Indications:* Infections of respiratory, gastrointestinal and genitourinary tracts and skin and soft tissues due to tetracycline-sensitive organisms, in patients with increased susceptibility to monilial infections. *Contraindications:* The drug is contraindicated in patients hypersensitive to its components. *Warnings:* Photodynamic reactions have been produced by tetracyclines. Natural and artificial sunlight should be avoided during therapy. Stop treatment if skin discomfort occurs. With renal impairment, systemic accumulation and hepatotoxicity may occur. In this situation, lower doses should be used. Tooth staining and enamel hypoplasia may be induced during tooth development (last trimester of pregnancy, neonatal period and childhood). *Precautions:* Bacterial superinfections may occur. Infants may develop increased intracranial pressure with bulging fontanels. In gonorrheal therapy, serologic tests for syphilis should be conducted initially and monthly for 3 months. *Adverse Reactions:* Glossitis, stomatitis, nausea, diarrhea, flatulence, proctitis, vaginitis, dermatitis, and allergic reactions may occur. *Usual Adult Dosage:* 1 capsule q.i.d. Continue for 10 days in Beta-hemolytic streptococcal infections. Administer one hour before or two hours after meals. *Supplied:* Capsules, bottles of 16 and 100. Each capsule contains tetracycline phosphate complex equivalent to 250 mg. tetracycline HCl activity and 250,000 units of nystatin. For Oral Suspension, 125 mg. tetracycline and 125,000 u. nystatin/5 ml., 60 ml. bottles. **A.H.F.S. Category 8:12**

BRISTOL

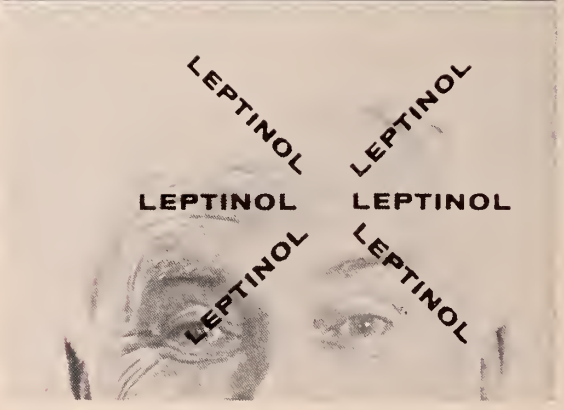
BRISTOL LABORATORIES
Division of Bristol-Myers Co.
Syracuse, New York 13201



When elderly patients display symptoms of apathy, mental confusion, memory lapses...

consider

LEPTINOL®



LEPTINOL® is a non-addictive stimulant which is a useful adjunct in elevating the mood of the elderly patient who displays apathy, mental confusion or memory lapses. It is a combination of pentylenetetrazol, niacin, thiamin and ascorbic acid which acts as a central nervous stimulant and which exerts its primary effect on the mid-brain and the medullary center. Because no addiction or intolerance is introduced, you may also find LEPTINOL® to be a welcome adjunct even to the treatment of slow degenerative diseases.

Each bi-layer tablet contains: Pentylenetetrazol 100 mg., Niacin 50 mg., Thiamine Hydrochloride 1 mg., Ascorbic Acid 20 mg. Dose—one or two tablets three times daily, one-half hour before meals. Maximum dosage is two tablets per dose, six tablets per day. Side effects—Excessive dosage may cause transient flushing, muscular twitching, hyperreflexia and convulsions, and respiratory paralysis. Use cautiously in elderly patients who are unstable or paranoid.

Contraindicated in patients with low convulsive threshold, epilepsy or severe hypertension.

LEPTINOL® is supplied in bottles of 100, 500 and 1,000 tablets.

VALE

THE VALE CHEMICAL COMPANY, INC.
Pharmaceuticals Since 1922
ALLENTOWN, PENNSYLVANIA 18102

A once-popular treatment for back pains was to have the seventh son of a seventh son stand or walk on the patient's back.





The pain of earache was allegedly relieved by holding a hot roasted onion to the ear.

For headache, a sovereign remedy was to wear a snakeskin round one's head.



A realistic approach to pain relief



Empirin'®

Compound with Codeine Phosphate gr. 1/2 No. 3

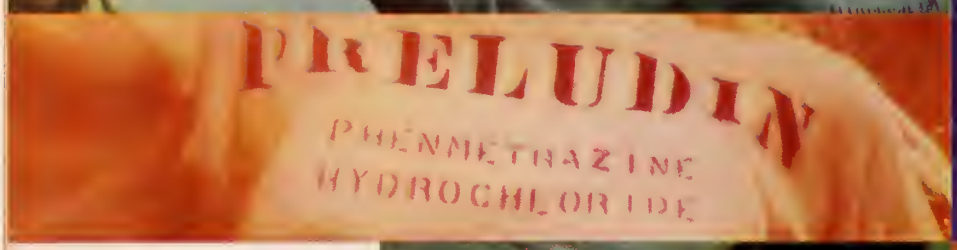
Each tablet contains:
Codeine Phosphate gr. 1/2 (Warning—May be habit forming), Phenacetin gr. 2 1/2, Aspirin gr. 3 1/2, Caffeine gr. 1/2.

keeps the promise of pain relief

'B.W. & Co.' narcotic products are Class "B", and as such are available on oral prescription, where State law permits.

BURROUGHS WELLCOME & CO. (U.S.A.) INC.
Tuckahoe, N.Y.











Preludin®
phenmetrazine hydrochloride

Preludin is indicated only as an anorexigenic agent in the treatment of obesity. It may be used in simple obesity and in obesity complicated by diabetes, moderate hypertension (see Precautions), or pregnancy (see Warning).
Contraindications: Severe coronary artery disease, hyperthyroidism, severe hypertension, nervous instability, and agitated prepsychotic states. Do not use with other CNS stimulants, including MAO inhibitors.
Warning: Do not use during the first trimester of pregnancy unless potential benefits outweigh possible risks. There have been clinical reports of congenital malformation, but causal relationship has not been proved. Animal teratogenic studies have been inconclusive.
Precautions: Use with caution in moderate hypertension and cardiac decompensation. Cases involving abuse of or dependence on phenmetrazine hydrochloride have been reported. In general, these cases were characterized by excessive consumption of the drug for its central stimulant effect, and have resulted in a psychotic illness manifested by restlessness, mood or behavior changes, hallucinations or delusions. Do not exceed recommended dosage.
Adverse Reactions: Dryness or unpleasant taste in the mouth, urticaria, overstimulation, insomnia, urinary frequency or nocturia, dizziness, nausea, or headache.
Dosage: One 25 mg. tablet b.i.d. or t.i.d. Or one 75 mg. Endurets tablet a day, taken by midmorning.
Availability: Pink, square, scored tablets of 25 mg. for b.i.d. or t.i.d. administration, in bottles of 100 and 1000. Pink, round Endurets® prolonged-action tablets of 75 mg. for once-a-day administration, in bottles of 100 and 1000. (B) R3-46-560-B

Under license from
Boehringer Ingelheim G.m.b.H.

For complete details, please see full prescribing information.

Geigy Pharmaceuticals
Division of
Geigy Chemical Corporation
Ardsley, New York 10502

Preludin® Endurets®

phenmetrazine hydrochloride **prolonged-action tablets**



They run a good chance of losing weight.

Exercise and Preludin run together in helping patients to lose weight.

Preludin often puts a natural curb on appetite and frequently promotes a sense of well-being. By boosting a dieter's spirit, Preludin may help patients get the exercise you may prescribe.

One Endurets tablet taken between breakfast and midmorning usually provides daylong and early-evening suppression of appetite.

Mild ulcerative colitis may be triggered here...



In mild ulcerative colitis, a number of factors can precipitate an attack: for instance, dietary indiscretion, such as eating raw foods, or emotional overreaction, such as that aroused by financial difficulties. No matter what causes the patient's sensitive colon to "act up," he soon suffers from acute discomfort...and often, from anxiety and apprehension as well. Such patients frequently respond well to adjunctive dual-action Librax® therapy.

Librax combines, in a single convenient capsule, the well-known antianxiety effect of Librium® (chlordiazepoxide HCl) and the dependable anticholinergic /antispasmodic effect of Quarzan® (clidinium Br). Therefore, as Librax helps to relieve the patient's excessive anxiety and reduce his overreaction to stress, it also, at the same time, helps to control hypersecretion and hypermotility, thus relieving spasm and abdominal discomfort.

With Librax, the dosage schedule is simple: 1 or 2 capsules, t.i.d. or q.i.d., will in most cases bring the patient significant relief of both the emotional and physical elements that contribute to his psychovisceral disorder.

Before prescribing, please consult complete product information, a summary of which follows.

INDICATIONS: Indicated as adjunctive therapy to control emotional and somatic factors in gastrointestinal disorders.

CONTRAINDICATIONS: Patients with glaucoma; prostatic hypertrophy and benign bladder neck obstruction; known hypersensitivity to chlordiazepoxide HCl and/or clidinium bromide.

WARNINGS: Caution patients about possible combined effects with alcohol and other C depressants. As with all CNS-acting drugs, tion patients against hazardous occupation: quiring complete mental alertness (*e.g.*, opera machinery, driving). Though physical and chological dependencc have rarely been repo on recommended doses, use caution in ministering Librium (chlordiazepoxide hy chloride) to known addiction-prone individ or those who might increase dosage; withdra symptoms (including convulsions), follo discontinuation of the drug and similar to t seen with barbiturates, have been reported. of any drug in pregnancy, lactation, or in wo of childbearing age requires that its pote benefits be weighed against its possible haza As with all anticholinergic drugs, an inhib effect on lactation may occur.

PRECAUTIONS: In elderly and debilit limit dosage to smallest effective amount to clude development of ataxia, oversedatio confusion (not more than two capsules per initially; increase gradually as needed and t

or here.



). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychotic patients. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

ADVERSE REACTIONS: No side effects or manifestations not seen with either compound alone have been reported with Librax. When chlordiazepoxide hydrochloride is used alone, drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally with chlordiazepoxide hydrochloride, making periodic blood counts and liver-function tests advisable during protracted therapy. Adverse effects reported with Librax are typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy and constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diet.

two good reasons for prescribing LIBRAX®

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

ROCHE
LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Public Enema No.





Claim the rewards of sparing your patients the tubes and tribulations of unpleasant enemas.

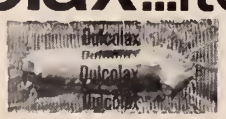
Compared to enemas, Dulcolax suppositories are a gentler and simpler way to empty the bowel. Gone are the tubing, the "accidents", and the bruised egos. Just one suppository, inserted against the bowel wall, usually brings about an evacuation within 15 minutes to an hour.

In the hospital, order Dulcolax for constipation or bowel cleansing. Your patients will often prefer it t embarrassing enemas. And you can be sure nurses will appreciate the saving in time and effort.

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Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms have occurred following abrupt discontinuance. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation, have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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Contraindication: Penicillin hypersensitivity.

Warnings: In rare instances, penicillin may cause acute anaphylaxis which may prove fatal unless promptly controlled. This type of reaction appears more frequently in patients with a history of sensitivity reactions to penicillin or with bronchial asthma or other allergies. Resuscitative drugs should be readily available. These include epinephrine and pressor drugs (as well as oxygen for inhalation) for immediate allergic manifestations and antihistamines and corticosteroids for delayed effects.

Precautions: Use cautiously, if at all, in a patient with a strongly positive history of allergy.

In prolonged therapy with penicillin, and particularly with high parenteral dosage schedules, frequent evaluation of the renal and hematopoietic systems is recommended.

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EDITORIALS

Osteopathy In The House Of Medicine

The more senior among us can remember when the "homeopath" was looked on with some reservation by the "regular" (or as it was then called, the "allopathic") physician. By now, this is of only historical interest. No one really cares whether a physician was backgrounded in an allopathic or homeopathic school. It may be that osteopathy will be facing a similar welcome to the house of medicine. At its December 1968 session, the American Medical Association's House of Delegates resolved that: "to assure the best possible health care to the American people, make available to students and graduates in osteopathy education of the same high standards as prevail in undergraduate, graduate, and continuing educational programs in medicine; provide avenues whereby qualified osteopaths may be assimilated into the mainstream of medicine."

To achieve those objectives, the AMA recomcomends that "accredited hospitals may accept qualified osteopaths on medical staffs; suggests that medical specialty boards may accept osteopaths for examination if they have completed AMA-approved internships and residency programs;" requests that AMA-approved residency programs be opened to qualified osteopathic graduates; suggests "opening AMA-approved internships to qualified osteopathic graduates;" recommends that "determination of qualification be made at the level of the medical staff, the county medical society, or the review committees;" and suggests that the AMA, state and county societies, and other affected organizations "may proceed to make such constitution and bylaw changes as are necessary to implement the foregoing."

The AMA House of Delegates suggested that "each county and state medical society may accept qualified osteopaths as active members" and instructed the AMA Council to prepare "appropriate amendments to the bylaws so that qualified doctors of osteopathy may be admitted to full and active AMA membership."

This seems to token the end of the rift between these two arms of the healing profession, serving as assurance that the acceptable osteopathic medical schools have achieved sound standards, and as evidence that, contrary to the plaints of some of its critics, Organized Medicine is not simply a closed shop or protective guild, interested only in its own members.

The Robot Pharmacist

More and more hospitals are buying drug dispensing machines. The feature of these devices is that they will deliver a unit dose package of tablets, capsules, or pills, and register the name of the patient, the name of the nurse operating the machine, the name and dose of the drug, and — probably — print the cost on the patient's bill all at once. Most of the devices are tamper proof and well secured against abuse or unauthorized operation. Some hospital pharmacists view this development with enthusiasm, since they feel it will relieve the pharmacist of such routine, nonprofessional duties as counting tablets or pouring tinctures from big bottles into little ones. Freed of these non-glamorous chores, the pharmacist will thus have more time for the professional skills of drug preparing and dispensing, and for professional advice on medication and supplies.

On the other hand, some pharmacists are uneasy about being mechanically separated from verification of the doctors' orders. In some hospitals, the devices may be used only when a pharmacist is off duty, though one wonders why, if they are safe to deliver medication at 2 a.m., they wouldn't be just as safe to hand out drugs at 2 p.m. The machines also bring up an interesting question as to the dif-

ferentiation between *dispensing* a medication, and *administering* it. If a practical nurse takes a bottle labelled "Aspirin, 5 grains," removes a tablet and gives it to a patient, is she "dispensing" aspirin or just "administering" it?

The physician is always haunted — more or less — by the fear that the drug order he writes will be misread, and the patient given Ornade® instead of Orinase® or Bellergal® for Geminal.® And this kind of error can be programed right into the machine. Perhaps the best protection against it is having a pharmacist (human) instead of a drug-dispensing machine between the doctor writing the order and the nurse administering it. In all probability, questions like this are not going to stop the whirring wheels of progress, but let us hope, at least, it will give us pause before we are all replaced by push buttons.

With Hostility, You Can't Win

It is hard to think of a pleasant diagnosis. No matter what the ailment, you are better off without it. However, the closest thing to a delightful diagnosis is "you're working too hard." The analogy of the storage battery is compelling. You have to rest to recharge the batteries.

And this is what makes the diagnosis delightful. Your symptoms now may be worn like a badge of honor. You are too conscientious. You work too hard. You have a right to sympathy from friends and coddling from a spouse. You are innocent of fault. Here at least is the great desideratum: sanctimony without criticism.

And the prescription? Also delightful. Atlantic City, Florida, the Bahamas, or Monaco, according to purse. Sleep late in the morning. Let others worry. Be waited on. No guilt. Indeed much righteousness.

Well, a doctor who says his name is J. Smith* has made a study of "overwork." Now Dr. J. Smith (a likely name!) found that half of the patients with the "overwork syndrome" were suffering from hostility to a supervisor or disagreement with the boss generally. This, it seems, produced symptoms in day laborers and also in middle management executives. As a matter of fact, a boss-ridden worker was likely to live in a wife-centered home, so that he didn't get much relief even when he was safely ensconced in what our humorous British brethren call his "castle." The tired feeling thus continued after the 5 o'clock whistle.

Of all the emotions, hostility is the most dangerous. It will, in this atom age, probably be the death of us. Hostility raises the blood pressure, pours acid into the stomach — and churns up the stomach walls too, and you know what *that* leads to. Hostility produces wheezes in the chest, pours excess sugar into the blood stream and stimulates peristalsis in the lower gut. No matter what you do with this hostility, you can't win. If you let it express itself, you go pounding on table tops and get hypertension. If you swallow it down, you get ulcers.

Somewhat neglected in Smith's roster is the role of ennui. Even a toothache seems less compelling when you are excited about your job. It is given to only a few of us (and we doctors are generally in this happy category) really to like our work. Thoreau† said that "the mass of men lead lives of quiet desperation." So boredom produces symptoms which may lead to the delightful diagnosis, *allergia operi*.

No, the diagnosis of "overwork" may be scientifically incorrect. But in a larger sense it is apt enough. Work that is anxiety-laden, work that is boring, work that generates hostility, is too much for most of us.

Take the afternoon off and get your batteries recharged.

* Smith, J.: *JAMA* 161:1038
† Thoreau, H. D.: *Walden* (part I)

ORIGINAL ARTICLES

Intermittent peritoneal dialysis with a permanent catheter need not be limited to university hospital settings. Here is a report of a successful case in a community hospital.

Intermittent Peritoneal Dialysis In End-Stage Renal Failure

Edwin Kellerman, M.D./Margate

Reports are available on intermittent dialysis, (both hemodialysis and peritoneal dialysis) in end-stage renal failure. However, these reports emanate from major teaching and research institutions. Here is a report on a patient with end-stage renal failure in a community hospital who was treated with intermittent peritoneal dialysis. The results obtained and the problems encountered will be of interest to physicians who might contemplate this therapy in this setting for those patients who are found to have terminal and irreversible renal failure.

Peritoneal dialysis during the first eight months of treatment was carried out in a conventional style with the repeated puncture technic using commercialy available disposable Stylet catheters. However, in the eighth month of treatment considerable technical problems ensued in the form of poor drainage from the catheter and repeated resistance to catheter insertion intraperitoneally, causing the decision to implant a permanent Silastic catheter in the abdominal wall into the peritoneal cavity.*

In the ensuing four months, this permanently implanted catheter functioned well. For dialysis we used the commercially available solutions in various combinations of glucose concentrations depending upon the state of over-hydration and the rapidity with which extracellular fluid could be safely removed without producing hypotension. All dialyses were started by a physician who determined the general plan of treatment. Changes of peritoneal dialysis bottles and responsibility for initiating and terminating infusions and outflows were carried out by the nursing staff on duty. Through the months of treatment the patient and his family were encouraged to carry out the mechanics of the peritoneal dialysis and the recording of vital signs. Sufficient experience and self-confidence were obtained by the patient and his family so that by the end of the year they could be entrusted to carry out this procedure under the direction and supervision of a physician and the nursing staff thereby reducing the amount of professional time required.

A twenty year old male was admitted following a severe protracted epistaxis. Kidney disease had been detected three months previously when he saw his physician for headache, and hypertension was found. Evaluation at that time revealed a blood pressure of 160/110. The BUN was 168 with a creatinine of 17. Urine outputs averaged 1500 cubic centimeters a day. There was moderate proteinuria with a normal urine sediment and no evidence of urinary tract infection on cultures. Retrograde pyelography demonstrated a small left pelvic kidney, and a normally located right kidney slightly contracted in size. There was no evidence of obstructive uropathy. He was discharged from the hospital with a 40 Gram protein low salt diet and a prescription for Aldomet.®

Readmitted three months later, he was critically ill. He had had a major epistaxis. Hemoglobin was 3.5 Grams per cent with a BUN of 244. The epistaxis was

* Kindly supplied by Henry Tenckhoff, M.D., Department of Medicine, Division of Kidney Diseases, University of Washington.

controlled with nasal packing. After blood replacement, a decision was made to institute peritoneal dialysis when he stabilized but remained in uremic coma. Following two short courses of peritoneal dialysis he was discharged ambulatory and free of symptoms with 10 Grams per cent of hemoglobin and a BUN of 66. Eleven days later he was readmitted to the hospital for treatment and the initiation of a chronic peritoneal dialysis program, when he developed lassitude and pericarditis with a BUN of 225. The following report deals with his clinical course over the ensuing twelve months while on an intermittent peritoneal dialysis program.

During the twelve months that the patient was treated with intermittent peritoneal dialysis he required two admissions a month for dialysis. Each period of peritoneal dialysis would last about 72 hours. His admission BUN would average 150 mg per cent. At the end of the dialysis the BUN would average 50 mg per cent. Serum potassium on admission would average above 6 meq/L; after dialysis it would average 4 meq/L. Potassium was not generally added to the dialysis solutions. It was usually necessary to use combinations of 1.5 per cent and 7 per cent dextrose solutions to reduce gross overhydration present on admission, which at times produced overt serious congestive heart failure. As a result of the use of hypertonic dialysis solutions, an average of twenty pounds of fluid were removed with each dialysis, rendering the patient edema free. On admission to the hospital the patient's blood pressure would average 200/130. At the termination of dialysis the patient's blood pressure was usually reduced to an average value of 130/100.

When the patient was brought to an edema-free state by the removal of sufficient extracellular water and sodium, the blood pressure came under satisfactory control. Usually the blood pressure found on admission would become even higher with the first few dialysis exchanges, or when a transfusion of packed red cells would be given for severe anemia during the first few months treatment. When the systolic blood pressure went over 200, small doses of intramuscular reserpine were used with effective results in lowering the blood pressure to safer levels.

The rate of accumulation of blood urea nitrogen, serum potassium, and body water was in large measure governed by the patient's adherence to his diet. He was intructed as to the use of a 40 Gram protein low salt, low potassium diet with restriction of fluid intake. When he would follow this program *exactly,* he would be satisfactory clinically and would not require dialysis more often than every three weeks. When he was less exact with his dietary program, dialysis at two week intervals or even oftener would be required. At times near lethal complications, secondary to rapid accumulations of catabolic products, would ensue. Inquiry was made as to the possibility of initiating one of the forms of dietary management utilizing protein of high biologic value to retard the rate of urea accumulation. However, this dietary management could not be obtained locally. With it and with the patient's strict adherence to this form of diet, it is possible that the interval between dialyses could have been extended somewhat beyond three weeks.

At the initiation of the program of intermittent peritoneal dialysis the patient's urine volumes averaged 1500 cubic centimeters a day. After his first peritoneal dialysis, daily urine volume fell to less than 500 cubic centimeters a day. Within a few months be became virtually anuric, excreting less than 100 cubic centimeters of urine a week. Despite his severely limited urine volumes his rate of blood urea nitrogen accumulation between dialyses averaged 5 to 8 milligram per cent a day. Between dialyses, with careful salt and water restrictions, his daily increase in body weight would be less than two pounds a day. Home steam-bath treatments were helpful in curtailing rapid fluid accumulations. A generally voracious appetite with limited self-motivation at times was a serious drawback to a strict dietary program of management.

There was need for a minimum of medication during this period of treatment. Aldomet® [250 milligrams three times a day] was used in an attempt to control interval hypertension. This was his only consistent outpatient medication. While in the hospital a preparation of a commercially available parenteral water soluble vitamin was used by daily intramuscular injection in the hope of retarding the development of peripheral neuropathy. Intramuscular reserpine was occassionally needed at the initiation of dialysis to control hypertension. For the first few months of treatment an oral cation exchange resin was employed to curtail potassium accumulation. Later, it was found to be unnecessary and was therefore abandoned. Digitalis preparations were not employed. Whenever evidence for a congestive circulatory state developed, hypertonic dialysis was always successful in relieving this abnormal state.

During the first few months of treatment, blood replacement (packed red cells) was given, usually on admission to the hospital when an average hemoglobin value of 6 Grams per cent or less was found, particularly if there would be some capillary oozing of blood about the peritoneal catheter after its insertion with the Stylet. In the last four months of treatment (after the insertion of the permanent peritoneal cathereter) blood replacement was not employed. Perhaps a more conservative program of blood replacement could have been used initially. With the removal of excess body water by the use of hypertonic dialysis, hemoglobin values were noted to rise during dialysis by as much as 2 Grams per cent. With the elimination of blood transfusions, average hospital admission hemoglobin values seemed to rise probably as a result of improved hematopoietic function so that admission hemoglobin values averaged 7.5 Grams per cent by the end of the first year.

During the twelve months of intermittent peritoneal dialysis, a minimum of laboratory data was required. Routine studies at the beginning of dialyses were hemoglobin, blood urea nitrogen, and serum potassium. However, the clinical condition of the patient usually was a better indication for the initiation of dialysis than any specific alarming laboratory value. Of interest was the fall in serum albumin from 4.3 to 2.8 Grams per cent with the known significant protein losses with peritoneal dialysis and without protein supplementation. Serial electrocardiograms during the twelve months revealed a stable pattern of mild left ventricular hypertrophy and ischemia. Serial chest x-rays were obtained. At the end of one year's treatment he exhibited clear lung fields with a large cardiac silhouette thought to be due primarily to a pericardial effusion, although significant myocardial dilatation and hypertrophy could not be excluded. Serum electrolytes, creatinine, uric acid, and alkaline phosphatase were not determined. At the end of one year's treatment there was no clinical evidence of metastatic calcification nor osteodystrophy.

Complications

Listed below are the complications encountered during the twelve months of intermittent peritoneal dialysis.

A. *Medical.*
1. Severe epistaxis.
2. Pericarditis.
3. Pericardial effusion.
4. Terminal orthostatic hypotension.
5. Hyperkalemic myopathy.
6. Congestive heart failure.

B. *Technical.*
1. Peritonitis.
2. Bleeding around stylet-placed intraperitoneal catheter.
3. Leakage about stylet-placed catheter.
4. Resistance to catheter passage intraperitoneally.

Severe epistaxis occurred only once, prior to the first dialysis. Subsequently there was no episode of spontaneous bleeding. Pericarditis with the classical form of chest pain and a typical friction rub developed during the second month of treatment. This resolved during dialysis, however, a pericardial effusion was suggested by chest x-ray and confirmed by radioisotope heart scan. This was kept under observation for several weeks until it was decided to do a pericardiocentesis. At this time, 600 cubic centimeters of sanguineous fluid were readily aspirated. In several days, the pericardial effusion reappeared. It subsequently disappeared with further dialysis. Five months later it reappeared during a period of markedly positive fluid balance and remained subsequently, without causing any cardiopulmonary embarrassment or pulsus paradoxus. Further pericardiocentesis was not attempted.

In an attempt to achieve "dry weight" and effective control of antecedent hypertension, considerable fluid removal with each dialysis resulted on several occasions in symptomatic orthostatic hypotension, when the patient would begin to ambulate prior to discharge from the hospital. This condition was always self-correcting within, at most, several hours so that his discharge was not significantly delayed.

During the eleventh and twelfth month of treatment, just prior to each dialysis, two

episodes of severe hyperkalemic myopathy occurred with virtual complete paralysis of the extremities. The serum potassium on each occasion was 7.9 and 10.2 meq/L respectively. The only explanation for this complication appeared to be antecedent severe dietary indiscretions. Within twenty-four hours of dialysis the extremity paralysis resolved and the serum potassium became normal.

Several episodes of congestive heart failure (or a circulatory congested state) developed when fluid balance became markedly positive. That primary myocardial failure was not of primary etiology was supported by the fact that the rapid removal of extracellular fluid and sodium by hypertonic dialysis resulted in prompt and lasting correction of the condition.

A number of significant complications of a technical nature occurred during the eight months of use of a stylet-placed catheter for dialysis. There were no technical problems with the permanently implanted catheter. Mild peritonitis occurred twice, heralded by abdominal pain and tenderness and cloudy dialysis drainage fluid. On the first occasion staphlococci coagulase Positive and Klebsiella were cultured from the catheter tip. This rapidly responded to the removal of the catheter and several days of oral erythromycin. The same organisms were cultured on the second episode of peritonitis, five months later during the seventh month of treatment. This time the dialysis was continued with the addition of Cephalothin® to each exchange of fluid with prompt recovery. Antibiotics were not used routinely prophylactically in the dialysis solutions.

On one occasion, significant bleeding occurred around the stylet-placed catheter. At another time, significant fluid leakage occurred about the stylet-placed catheter. On each occasion, prompt correction was obtained by the placement of purse-string sutures about the catheter. In the eighth month of treatment catheter placement became exceedingly difficult with great resistance to its passage and subsequent poor drainage through it, attributed to the development of intraperitoneal adhesions. This led to the decision to try a permanently implanted catheter which surprisingly, in the succeeding four months, always gave satisfactory inflow and outflow rates.

Results

This patient, during the twelve months of intermittent peritoneal dialysis, achieved virtual full rehabilitation and a symptom free state in between periods of hospitalization for dialysis. He was fully active and ambulatory. He worked and was self-supporting. He also attended college part-time. His activity ability was so great that he had to be discouraged from participation in neighborhood basketball which he had enjoyed prior to his illness, for fear that he might overtax his cardiovascular system weakened by prolonged uremia and hypertension. He remained mentally clear although his degree of full cooperation with the treatment program, particularly its dietary aspects, left something to be desired at times. With repeated admonition in this area and with his personal observation of the near fatal complications which could develop with dietary indiscretions, a greater degree of cooperation was achieved by the twelfth month of treatment.

Summary

Here presented is a case history and discussion of a patient with end-stage renal failure treated by intermittent peritoneal dialysis over one year in a community hospital. Until such time as other forms of therapy – transplantation and chronic hemodialysis – become more generally available and successful, this form of therapy may be a reasonable alternative to death for a patient with terminal renal failure within the limited capabilities of a community hospital.

17 South Essex Avenue

The views here expressed are those of the author. Dr. Karel is not speaking for The Medical Society of New Jersey nor for St. Elizabeth Hospital.

National Emergency Medical Care Centers*

Jack R. Karel, M.D./Hillside

Ten thousand people are injured each day in the United States. Every fourth American will seek service in an emergency room this year. One of two persons will be hospitalized from auto accidents.[1] These facts highlight the problem of emergency medical care. In the words of the distinguished physician, Dwight Wilbur, speaking as President-Elect of the AMA, emergency medical service in the country is inadequate, is outmoded, and is not capable of meeting demands.[2] Twenty thousand people die in automobile and other accidents because of inadequacies in emergency medical services.[3] Accidents are the major cause of death between the ages of one year and 37 years because of the crowding of areas, many of which are being filled by machines.[4] Population of the country is expanding. Medicare and Medicaid have produced a situation where a fifth of hospital beds are now occupied by patients 65 years and over. This trend will accelerate as more people avail themselves of Medicare. In turn, this has caused a decrease in available bed capacity for emergency medical and surgical patients.

Hoards of people go directly to emergency departments of hospitals and call ambulances to get there. Sometimes they go directly to the emergency room because they move frequently and don't know a local physician.

Many enter the emergency room because of its convenience or the unavailability of their family physician. They come to emergency rooms for treatment of ailments that should be handled in a doctor's office. The emergency room has become the mecca for the welfare or indigent patient. All of this has a direct effect on the operations of the modern hospital. We made a study of the patient load in the emergency department of a modern hospital with a bed capacity of 354 located in a residential and industrialized city of 125,000. Two other general hospitals are in this city whose bed capacities are 313 and 119 respectively. The total number of patients appearing in the emergency department during the months of January and June of 1968 were studied since they are typical of winter and summer months. See Table 1. The total number of patients that would be expected to appear during the entire year of 1968 are shown in Table 2 and were determined by multiplying by six the numbers shown in Table 1.

This survey reveals:

1. The majority of patients (almost two to one) seen in the emergency rooms are not really emergencies.

2. Six times as many emergency *surgical* patients as *medical* go to the emergency departments for treatment.

3. Many welfare and other indigent patients go to emergency departments repeatedly for treatment of non-emergent conditions.

All this points up the need for aggressive action to counter the carnage on our highways, reduce accidents generally and to make available to the medically afflicted and injured the

* From the St. Elizabeth Hospital (Elizabeth, New Jersey) Emergency Department. Dr. Karel is Chairman of the Committee on Emergency Medical Care for The Medical Society of New Jersey, and is also Deputy Coordinator of Civil Defense and Disaster Control for Union County (N.J.).

Table 1
VISITS TO EMERGENCY ROOM—JANUARY 1968

EMERGENCY			EMERGENCY AND NON-EMERGENCY		
Medical	Surgical	Emergency Medical and Surgical	Medical	Surgical	Emergency and Non-Emergency Medical and Surgical
83	309	392	774	809	1,583
		VISITS TO EMERGENCY ROOM—JUNE 1968			
96	763	859	725	1,137	1,862
		VISITS TO EMERGENCY ROOM—JANUARY AND JUNE COMBINED			
179	1,072	1,251	1,499	1,946	3,445

Table 2
PROJECTED ANNUAL VISITS TO EMERGENCY ROOM—1968

EMERGENCY			EMERGENCY AND NON-EMERGENCY	
Medical	Surgical	Emergency Medical and Surgical	Medical	Surgical
1,074	6,432	7,506	8,994	11,676

Table 3
CONSOLIDATED PROJECTED VISITS TO EMERGENCY ROOM—1968

EMERGENCY				
Medical	Surgical	Emergency Medical and Surgical	Non-Emergency Medical and Surgical	Emergency and Non-Emergency Medical and Surgical
1,074	6,432	7,506	13,164	20,670
5.19%	31.11%	36.32%	63.68%	100%

best medical care that can be given. Emergency departments of hospitals must *not* be burdened with responsibility for non-emergency patients.

I recommend the development of emergency medical care centers across the United States (in every well populated metropolitan area)—centers to which victims of injury or illness will go – day or night – and when physicians are unavailable to them or are not known. These centers should also be used by welfare patients and the indigent. At these emergency medical care centers, triage would determine whether hospitalization or outpatient therapy at the hospital clinic is required. I recommend that these centers be subsidized by municipal or county governments and that they be autonomous divisions of government operated by professional medical and paramedical personnel, with a physician Director.

References

1. From paper delivered January 15, 1968, AMA National Conference on Emergency Medical Services.

2. Wilbur, Dwight, M.D. Paper delivered at above conference.

3. *JAMA*. 24:10 (June 26, 1968).

4. From paper delivered January 15, 1968, AMA National Conference on Emergency Medical Services.

115 North Avenue

Depression, here viewed as a metabolic or biochemical disorder, is effectively approached through "physical" as well as psychological methods of treatment.

The Recognition And Management Of Depression*

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The problem of depression is faced more often by physicians in family practice than by psychiatrists. Some 70 per cent (or more) of patients admitted to any general hospital are seriously disturbed emotionally regardless of their underlying physical complaints. In at least 20 per cent of hospital admissions, the underlying problem is unrecognized depression. More human suffering has resulted from depression than from any other single disease.

The somatic masks of depression are many and are often highly misleading. The diagnosis would be missed much less frequently if the physician would look beneath physical symptoms that don't quite ring true. When the depressed patient comes for treatment he rarely complains of depression. He may even deny that he is depressed. He complains instead of physical symptoms such as headache, fatigue, loss of weight, insomnia, and other somatic complaints. He may burden the physician with a barrage of symptoms which have their basis in autonomic imbalance. Some, indeed, have active organic disease which may have precipitated their depression and its accompanying symptoms, such as fatigue, anorexia, loss of weight, sleep disturbances, anxiety, headache, and mood lability. These are particularly severe when the depression is an accompaniment of organic disease associated with a chronic illness.

Depression is unrecognized as such in probably 70 per cent of these people. If all depressed patients were identified and treated promptly, not only would the suicide rate be greatly reduced but, what is even more important, the day to day functioning of patients with depression (even those afflicted simultaneously with organic illness) would be greatly improved.

Physicians may feel uncomfortable and irritated when confronted with patients whose symptoms cannot be explained by the results of tests or relieved by what he prescribes in treatment. Physicians may find themselves very uncomfortable in the presence of patients with considerable anxiety and hostility.

It is important for the physician to be conscious of his own reactions because of the exquisite sensitivity of the depressed patient to rejection. Symptoms for which no somatic cause can be found may in fact be the patient's device for reaching out to a physician who is capable of accepting and understanding. If the physician is made uncomfortable and tends to withdraw, the patient will quickly sense this attitude and react adversely. Physicians who respond in this way to a depressed patient should, if possible, try to get someone else to care for the patient. It is unlikely that these feelings can be concealed from the patient. But the physician who can

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accept and tolerate the depressed patient will be in a strategic position to help in preventing the catastrophic complications of what is really a very treatable illness.

Types Of Depression

The practitioner should decide whether the depression is secondary to some organic disease or whether it is a primary depression. The six major categories are:

a. *Reactive Depression:*† Depression is, in fact, a normal happening in a patient's life pattern when intolerable conditions develop for him. In such cases one can speak of the depression as a "reactive depression."

b. *Neurotic Depression:* In highly sensitive persons, depression may arise under circumstances which are well tolerated by others. This type of depression may then be classified as "neurotic depression" if it frequently recurs.

c. *Iatrogenic Depression:* Depression may result when certain types of drug are administered (iatrogenic depression). Among the better known drug-induced depressions are those associated with such agents as reserpine or cortisone.

d. *Involutional Depression:* Depression is often the product of certain natural events in the biology of the person, e.g. the menopause in women and aging in both sexes.

e. *Endogenous Depression:* Depression may have a metabolic origin, perhaps an actual genetic basis. This is the type of depression occurring in a certain type of individual with the "cyclothymic" constitution ("endogenous depression").

f. *Schizo-affective Disorder:* Depression may be the by-product of a schizophrenic psychosis.

Reactive Depression†

Patients suffering from reactive depression may have only a few signs of a depressive syndrome or of an underlying personality disorder. They are nevertheless extremely unhappy about certain aspects of their lives. Commonly they come to the doctor to seek advice about some incidental matter such as an ache or a pain. It quickly becomes clear however that they are troubled actually by some "personal problem" such as impending failure at college, threatened dissolution of a marriage, serious loss in the stock market, the loss of an arm, leg, uterus, or stomach, the loss of a loved one, the loss of a home. In some instances reactive depression may result from failure to achieve a particular goal, e.g. to be elected president of a local organization. This, too, represents a loss, the loss of self-esteem.

† Under the new (1968) nomenclature, this is now called "depressive reaction."

Neurotic Depression

These are common forms of depression. Here, you are dealing with a patient who suffers from an inadequate technic in coping with the problems and disappointments of everyday life. Such people are unable to overcome even a moderate obstacle. Whatever equilibrium they may develop is maintained at the extravagant cost of constant self-management coupled with a state of masked tension. Suicide may be attempted as a way of expressing resentment toward the world which has frustrated their progress toward their goals.

The person with neurotic depression has a long history of "hangups." In contrast to the patient with reactive depression (who is suffering from a loss befalling him in adult life), the neurotic depressive suffers his loss early in life at the time when the patterns of his personality are imprinted. This is the loss of self-esteem or sense of his own value. His self-devaluation begins in childhood, and reaches its full power to devastate in adult life. The impairment of self-esteem and the loss of the sense of worthiness sap the person's joy of living and blunts his incentives to be part of the world about him.

Endogenous Depression

Statistically the endogenous depression (which is the depressive phase of the classic manic depressive personality) is uncommon. It is regarded, at present, as actually a metabolic illness. This has been shown by biochemical and genetic studies. For example identical twins with the trait for endogenous depression, even though widely separated early in life, have been shown to develop their symptoms at approximately the same time of life and in the same severity. The "concordance rate" in such cases amounts to 98 per cent!

The genetic trait may express itself early in life in the typical "cyclothymic" pattern. Such a person is "way up" at times, extremely active, abnormally cheerful and outgoing, expansive also in his activities such as buying two or three automobiles or two houses. This phase is followed in time by the opposite in which the subject is completely retarded, unable to eat or to sleep. Subsequently, when he regains some capacity to act, he may resort to suicide. The cyclothymic type of person is fairly common. However, the exaggerated exdepressive psychosis is quite rare. In some, its first manifestation may not occur until late in life, when it then takes the form of *involutional melancholia*. Even here, factors in the person's life pattern and environment may play a large precipitating role in the disorder.

Senile Depression

In many older persons who develop senile intellectual patterns associated with some degree of disorientation for time or place, depression may also develop. Such "senile depressions" are often the result of external factors or events such as loss of contact with friends and families. In this sense it may represent actually a variety of reactive depressions. As the result of progressive withdrawal from contact with other people the aging individual loses more and more contact with everyday reality, undergoing a type of "sensory deprivation" as a result of which he develops in turn a variety of delusional states and progressive memory loss.

Schizoaffective Depression

Here, you are dealing with a person who presents some schizoid traits and who also happens to be depressed. Obvious and clear psychotic symptoms rarely develop in these people so that at first they may resemble patients in any of the other groups described. Only after beginning treatment does one come to recognize the serious nature of the underlying disorder. These people state that for some time they have felt "empty" and "uninvolved" and that life has "held no meaning" for them and that they "just didn't fit in." They feel conspicuous or "different" and experience discomfort in groups of people, however congenial, and develop a feeling of unique inferiority, hopelessness, and helplessness. Because of their social isolation and chronic emotional impoverishment they are particularly susceptible to long periods of depression and may make serious suicide attempts. They are characterized by marked personality and ego defects. Their problem is a chronic one and usually they cannot remember a time when they were truly happy. Life for them has been one crisis after another and crises with which they are seldom able to cope. They are sensitive, introspective individuals and are often exquisitely sensitive to their depression. These people are extremely difficult to treat.

Somato-psychic Depression

This group includes depressions that arise out of illness. (This term is employed in reference to the converse of "psychosomatic" disorder, the condition in which somatic illness arises from the psyche.

a. *Depression after Coronary Attacks:* The common example of somatopsychic depression is that of the hard driving business executive 45 or 50 years of age who is struck down in the midst of full activity with a coronary attack. It is the rare person who can come through such a serious threat to life involving such upheaval in his entire mode of living and such profound loss of self-confidence and yet behave philosophically about such an experience. Depression is in fact the normal reaction to a heart attack. Indeed if the patient fails to show obvious evidences of being depressed one might have reason to suspect his mental state and regard his reaction as bizarre if not an evidence of outright denial or psychosis.

Because coronary attacks are the business of the family physician or internist, not of the psychiatrist, part of the physician's task in the rehabilitation of the coronary patient is to rehabilitate his psyche. Every good physician recognizes this principle and applies it in actual practice. His attitude is one of con-

tinuing encouragement, reassurance, and restoration of the patient's confidence in the future by giving him positive instructions about proper diet, avoidance of tobacco, proper habits of rest and relaxation, all with the idea of preventing future attacks and returning him to active productive living. The physician who has this type of understanding does all he can to allay fears and misgivings by promoting the patient's interest in physical as well as intellectual activity, encouraging him to exercise ("to promote formation of collaterals") and, if anything, minimizing the importance of taking additional electrocardiograms and repeating blood enzyme studies, once these have reached a stable level. By this means he is doing all he can to prevent the patient from becoming preoccupied with his physical illness and swallowed up by the anxiety engendered by being required to take frequent tests and re-tests long after the acute stage has passed.

b. *Depression after Infection or Trauma:* The same general principles apply to any patient who suffers a physical illness, whether one which requires surgery or any other form of major treatment. For example patients who develop a viral infection, especially influenza and related infections, require much encouragement to overcome their feeling of being "pooped out." This occurs frequently in the usual postinfluenzal asthenia. They should not be permitted prolonged bed rest for psychologic reasons just as much as for physical reasons, e.g., the risk of thrombophlebitis and other complications. The same rule applies in the case of patients who have been immobilized with a fracture of the hip for a long period of time. Their tendency, especially in the case of the elderly patient, is to give in to introspective feelings and anxieties and to lose their hold on their previous sense of self-sufficiency.

c. *Emotional Reactions to the Diagnosis of Cancer:* Cancer patients often deny or repress any awareness of their illness. Their reaction to the diagnosis often involves feelings of hostility and of guilt as well as an overt depression. To the patient his tumor may appear to be disgusting, dangerous, and foreign and creates a deep sense of self-devaluation. In contrast to the patient with cancerophobia (who is suffering from an imaginary cancer), the patient who knows of his cancer may develop an attitude of extreme denial of illness and even deprive himself of important therapeutic possibilities. The physician must learn how much his patient with cancer can tolerate psychologically in the way of information about his disease, and to do this he must listen carefully to what his patient has to tell him. In many cases, cancer patients suffer great anxiety and develop a deep sense of mistrust because they have been told a lie or something that they could not possibly believe or because something in the way of information was offered casually one week only to be abandoned the next. All patients with malignant disease have some awareness of its presence. At the same time they tend to avoid or deny their awareness in some way because cancer represents the ultimate threat to the integrity of the body and life. In this respect they act in a manner which characterizes their usual reactions to serious threats in their previous life experiences. For cancer patients the greatest threat in many cases is not so much the thought of death but rather of pain, helplessness, rejection, and progressive isolation. They have an intense fear of abandonment. Death itself is often equated in their minds with abandonment. In the chronically ill person this fear of being unloved and isolated is prevalent.

It is true, of course, that in some instances, an unusual person will insist that you tell him the full truth so that he knows what his prospects are and will therefore be able to put his affairs in order. In such instances one may be well advised to tell the patient the true diagnosis. However, the suggestion which has sometimes been made that patients should *always* be told when they have cancer is based on faulty understanding of the personality of the ordinary patient. One should, of course, tell the patient's wife or other responsible family member the nature of his condition. On the other hand it is perhaps sufficient to tell the patient at the very most that he has

a "low grade tumor" or even a "kind of tumor which may become malignant if it isn't treated properly," but to avoid if possible the unrelieved, starkly shattering impact of the words "malignancy" or "cancer" with all their implications and stigmatizations. One must allow the patient to maintain whatever ego defenses he can muster for himself without breaking them down with too much information or explanation.

d. *Obesity and Depression:* In many instances obesity is a precursor of emotional illness. In spite of the fact that the majority of depressed people lose appetite and lose weight, many people who are depressed will overeat.

Furthermore obesity may be an indirect cause of emotional disturbance when it leads to unregulated use of certain drugs capable of provoking depression. An obese patient may, for example, raise his own dose of amphetamine to as much as 80 milligrams a day in the desperate effort to lose weight, sometimes with the addition of 8 to 9 grains of thyroid extract, along with digitalis, diuretics, and other drugs intended to control appetite and produce dehydration. When these drugs are withdrawn because of other side-effects a rebound phase of profound depression may ensue. The depression may be greatly aggravated by the loss of potassium that results from the use of diuretics.

e. *Amphetamines and Depression:* The wearing off of the amphetamine response is associated with profound depression. Indeed, amphetamine addiction is easily acquired and youngsters who get their start on small doses generally find it necessary to increase the dose steadily until finally they reach the level of intravenous Methedrine® ("Speed") in big doses. In other instances amphetamine gives youngsters their start to marijuana, and then to LSD and heroin which may in turn give rise to disastrous psychological complications of other types.

f. *Other Drug-Induced Depressions:* Soon after reserpine was introduced for the treatment of hypertension it became evident that one of its most serious side effects was mental depression. In some instances this occurred even with small doses. Other agents used in treatment of hypertension, e.g., guanethidine and dopa, have also been associated with depression.

Drugs used in the treatment of emotionally disturbed patients have also been found occasionally to provoke profound depression rather than relief. This has been found to be the case chiefly with the major tranquilizers (chlorpromazine) given to people who are already depressed.

g. *Depression and Electrolyte Imbalance:* Agents (particularly diuretics) which promote the loss of potassium from the body, or the converse, sodium retention, may have a profound effect on a person's emotional state. The same principle probably underlies the emotional disturbances associated with the action of certain steroid hormones. One example of depression related to electrolyte imbalance associated with the action of steroid hormones is the premenstrual depression seen in some menstruating women associated with retention of water, i.e., swelling of the breasts, weight gain of 3 to 6 pounds, bloating of the abdomen, headache, and so on. The premenstrual depression syndrome may involve the action of hormones of the adrenal cortex, particularly aldosterone. In some female subjects water retention produces brain swelling and even signs suggestive of brain tumor (pseudotumor cerebri), i.e., headache, nausea, vomiting, and papilledema with loss of vision.

Psychiatric disturbances may result from therapeutic administration of steroid hormones and ACTH. Conceivably, these are explained by their leading to a deficit in potassium, particularly intracellular potassium. The association of psychiatric disorder with Cushing's disease and other states of adrenocortical hyperfunction has been known for a long time.

h. *Silent Cancer and Depression:* In some instances a malignancy can produce a depressive syndrome even when the patient is un-

aware of the cancer. This is particularly true with carcinoma of the pancreas and carcinoma of the lung. A malignancy of the body of the pancreas may produce depression as the result of the difficulty in diagnosis of the deeply penetrating epigastric pain referred to the back and the associated lassitude and loss of appetite.†† In carcinoma of the lung, the depressive syndrome may be related to endocrine abnormalities, particularly the tumor-induced Cushing's syndrome associated especially with "oat cell" cancer.

i. *Depression Associated with Organic Brain Disease:* Depression may result from actual intracerebral disease, particularly brain tumor. The famed composer, George Gershwin, had been under treatment by a pschoanalyst for five years before his death from a frontal lobe tumor.

Other organic syndromes which affect the central nervous system may also underlie certain types of depression. These include central nervous system arteriosclerosis and systemic lupus erythematosus. In the latter instance the patient's familiarity with the ominous nature of the disease may be as much a cause of the depression as the organic changes produced in the brain by the disease itself or electrolyte changes resulting from steroid therapy.

j. *Depressive Syndromes in Other Organic Disorders (Rheumatoid Arthritis, Ulcerative Colitis, and so on):* Rheumatoid arthritis is a common background for serious depressions, not only because of the profound functional impairment produced by arthritis but also because of a paradoxical effect of steroid treatment. Thus, in some cases of rheumatoid arthritis profound depression may occur shortly after the patient experiences *relief* of his disability! In certain instances an organic disease gives a patient enormous protection by relieving him of burdensome responsibilities, permitting him to enjoy leisure, to watch TV endlessly, and to command the solicitude of all about him. Abrupt cure of the disability may therefore rob the patient of all that he has acquired through this defense mechanism and plunge him into a profound depression. The doctor must be on guard therefore against curing such a protected patient too quickly, whether by curing his arthritis or merely providing relief of simple heartburn for which the patient had been doctoring himself all along with Probanthine® and Gelusil.® Even chronic intractable eczema may become a defense mechanism against responsibility and if cure occurs too quickly it may precipitate a serious depression.

Ulcerative colitis is more complicated. In many instances there seems to be an interaction between psyche and soma in which a deep seated emotional disturbance creates the background of organic disease. In this instance the physician should guard against probing too deeply. His well intentioned efforts may produce in fact a serious exacerbation of colitis or may precipitate a profound psychosis.

k. *Endocrine Dysfunction and Depression:* The association of depressive states with steroid or ACTH treatment or with Cushing's disease has been mentioned above. The endocrine background of depression does not end with these. Thus, a severe depression may be the herald symptom of myxedema. Hyperthyroidism on the other hand may be associated with intense anxiety. If the anxiety symptom becomes particularly prominent it may put the clinician off the track of the correct diagnosis. In differential diagnosis keep in mind that the patient with hyperthyroidism has moist warm palms whereas the neurotic depressive has moist cold palms. In doubtful cases one can quickly confirm the diagnosis with the PBI, T_3, or I^{131} uptake tests.

Hypoparathyroidism occurring either as an idiopathic disorder of the parathyroids or following thyroidectomy may produce depression with or without paranoid symptoms. Recently a 45 year old woman was interviewed because of severe depression which made her

†† Perhaps this is related to pressure on the celiac plexus — S. E. Moolton, M.D.

incapable of responding or even giving her name to the examiner. Trousseau and Chvostek signs soon led to the correct diagnosis, which was confirmed by her low serum calcium level and corrected by administration of dihydrotachysterol.

Hyperparathyroidism associated with high serum calcium may also cause depression which in the more acute forms may progress quickly into stupor (hyperparathyroid crisis) and end fatally. Keep this diagnosis in mind in any patient who develops continuous nausea, profound muscular weakness *and polyuria* approaching the severity of diabetes insipidus.

One of the classical signs of depression in males is loss of sexual potency. In the case of the aging male whose chief complaint to the physician is impotence one should not be too quick to label it an endocrine disturbance and administer testosterone. More thorough study may reveal that his true problem is a serious depression.

Hypoglycemia has been emphasized at such great length as a cause of psychoneurotic depression and other psychiatric disturbances that physicians have developed a tendency to lean heavily on this diagnosis and ignore more serious disorders such as a meningioma or other slow-growing intracranial tumor.

Clinical Evaluation Of Depression

a. *Family History:* The history may yield important information, particularly a history of depression in other members of the family. A history of one or more suicides in a family has been shown to have statistical significance. These data may mark the patient immediately as a possible victim of endogenous depression (manic-depressive depression).

b. *Somatic Complaints:* The parade of physical complaints of depressed patients has already been described. Severe sleep disturbances, loss of appetite, and loss of weight suggest a deeper disturbance, i.e., psychosis, rather than a reactive or neurotic disturbance. Severe agitation coupled with severe and recurrent somatic symptoms point to the possibility of an involutional psychosis. Many of these complaints, i.e., various types of pain, digestive disturbance, headache, etc., may give rise to a very extensive and very expensive workup with completely negative results. This disproportion between the multiplicity of symptoms and the paucity of organic findings is one of the important alerting evidences of depression. ("The words don't fit the music.")

In such instances the physician is often tempted to tell the patient that there is nothing wrong with him. Nothing could be farther from the truth. The fact that he cannot make a diagnosis of organic disease does not exclude the fact that his patient is suffering. To tell such a patient that his disorder is "imaginary" may have a shattering effect. One of the basic causes of depression, is loss of self-esteem. To be accused, therefore, of imagining an illness is an additional blow to the patient. Furthermore, it is a mark of the physician's own ignorance. Biochemical investigations have shown for example that the patient is undergoing some type of metabolic upheaval as part of his depression. Evidence has been obtained that increased output of 17-hydroxy-steroids in the urine may have important predictive value in uncovering the presence of suicidal impulse.

c. *Prediction of Suicide:* Merely asking the patient whether he is depressed may fool the physician. In fact the risk of suicide is much higher in the patient who says, "I'm not depressed, I'm fine," than in the one who admits to being sad. Actually the admission of being sad is somewhat contrary to our society's tradition ("It's un-American"). It is a confession that the patient is unable to keep up with the others; he can't work as well and can't make as much money. Everyone feels that to acknowledge illness is demeaning of one's self, a proof of unworthiness. The common response to the greeting, "How are you?" is usually, "I'm fine, thank you."

The Physician's Role In Managing The Depressed Patient

The family physician occupies the frontier position in all medical encounters of the depressed patient. Once he has excluded organic disease it is his responsibility to make a meticulous survey of the patient's emotional status so that he can, at least recognize the existence of depression and thereby prevent suicide. He must express sympathy not only by word but also by manner and gesture. He must avoid any attitude of annoyance or impatience about his patient's failure to comply promptly with his instructions. Although he runs the risk of becoming too much involved with the patient's problems to accomplish anything useful, he must nevertheless be willing to listen to the patient and to listen patiently and with respect and sympathy, both verbally and through non-verbal communication.

Loss of self esteem (which is the most important precipitating cause of depression) provides the physician with his most important approach in treatment. The doctor wants to help the patient regain a feeling of ego strength by helping him lose his sense of guilt, lose his fears, and "ventilate" his angers and hostilities. The physician should, therefore, never presume to make judgments on the patient's derelictions from the ordinary standards of conduct or morality. In the first place this is not his proper role. He should never scold the patient for such actions nor act in too pontifical a manner (the "master-slave relationship") but should try to reach out the hand of friendship and understanding.

Every physician is familiar with the role of the autonomic nervous system in production of physical symptoms. What he must also remember is the psychological significance of symptoms of autonomic imbalance and the degree to which they bear witness of the presence of serious depression. Excessive sweating, urinary frequency, signs of irritable colon, tension headache, heartburn, and other digestive disturbances as well as palpitation and "shortness of breath" (sighing respiration) are among the common autonomic manifestations of depression.

Fatigue without obvious organic cause is a common complaint of many people coming to physicians and almost invariably proves to have an emotional basis. Fatigue and "tiredness" in these patients represent an unconscious inhibitory impulse to withdraw from activity. The patient's posture, facial expression, and gestures similarly reveal his lack of zest for living and doing. On the other hand the discerning physician should watch out for the patient's denial of these or related symptoms accompanied by a disarming smile. Such denial, as already indicated, may have ominous significance in portending a suicide effort.

Sleep disturbances are common complaints by patients and are particularly revealing of the depressive state of mind. The difficulty in sleep may involve the entire sleep cycle so that the patient may be unable to fall asleep easily. This is much less serious than the sleep disturbance associated with early awakening, e.g., 4 or 5 a.m., particularly on a Sunday morning when ordinarily there is no requirement for such early awakening. In such instances the physician should be on the lookout for a much deeper, more serious type of depression, such as endogenous depression.

Loss of appetite is another important clue. Be on guard when a patient reports a significant loss of weight without other obvious cause. Conversely some depressed patients gain weight because of their feeling that food can relieve anxiety. The loss of appetite and consequent loss of weight may represent a symbolic form of atonement for guilt. The depressed person is obsessed with self-criticism and hostility against himself ("retroflexed rage") arising out of his sense of hopelessness and helplessness and his inability to concentrate or to generate motivation for normal activities. Fasting is a classic form of self-punishment either on the part of the individual or of the social group, in which it represents public atonement for sins as part of a religious exercise.

In some instances the inward tensions are accompanied by a deep sense of anxiety accompanied by agitation. Such anxiety may border on panic. This is particularly the case in the patient with involutional melancholia, a disorder which affects women between 45 and 55 and men between 55 and 65. The characteristic finding in involutional melancholia is agitation, depression, and a variety of somatic symptoms. Along with these is loss of sexual drive, slowed thinking, and marked diurnal swings in mood.

Biochemical And Neurophysiological Factors In Depression

New avenues of interpretation and treatment were opened when Hess (whose work won the Nobel Prize) divided the organization of the diencephalon into two distinct systems: the ergotropic and the trophotropic. The ergotropic increased sympathetic activity, preparing the body for fight or flight, while the trophotropic influenced parasympathetic activity (nutrition, repair). The discovery of large quantities of norepinephrine and serotonin in the hypothalamus focused attention on the role of these mon-amines as neurohormones capable of influencing these functions of the central nervous system. In general terms the posterior hypothalamus, which is concerned with the "ergotropic" activities of the central nervous system, is now recognized as the site for formation of norepinephrine as well as ACTH. Centers in the anterior hypothalamus are concerned with trophotropic functions and these centers involve the formation of serotonin, which acts in an opposite fashion, including also the inhibition of ACTH formation. Norepinephrine and serotinin are apparently concerned in the production of moods. According to present concepts the depressive state results when both of these are deficient or when both accumulate because of deficiency in the enzymes (monamine oxidases) which normally dispose of them.

Modern antidepressant psychopharmacology is based on the principles established in this connection. The psychotropic drugs in common use have been shown either to increase the levels of these agents by inhibiting their destruction (monamine oxidase inhibitors such as Marsilid,® Nardil,® Monase,® and Parnate®) or to facilitate the action of norepinephrine and other catecholamines at the synapses by some form of sensitization which increases their availability (tricyclic drugs such as Tofranil® and Elavil®). Increased steroid concentration (hydroxycorticoids) in blood and urine has on the other hand been correlated with the state of anxiety rather than depression.

Psychodynamic Factors In Depression

The underlying factor in depression is a loss of self-esteem. The loss may be real or symbolic.

In a general way, depression is a form of mourning for loss of self-esteem or sense of worthiness. This type of depression is normal in any person who suffers a serious blow to his pride or ambition but is generally overcome in a matter of weeks or months. In the case of the patient who is depressed in the sense of a primary psychiatric disorder the period of "mourning" lasts for months and years.

Depression may stem from early separation from the parent or insufficient attentiveness by the parent. These "imprint" the child with the fantasy of having something basically wrong with him, something that makes him unacceptable to others. He then fears to establish firm emotional relationships with other people because of his fear of the pain of being deserted. He feels doomed to loneliness and to hopelessness about ever finding some meaning in life. He is overwhelmed with his sense of despair and the certainty that his course is to be forever joyless and doomed.

To protect himself from the constant fear of rejection the neurotic depressive suppresses the feeling of hostility and aggression which become a basic component in his disorder. Instead he bottles up his anger, whenever and however it is aroused, because of his in-

tense fear of loss of approval. Normal feelings of anger and aggression are turned inward upon himself. This attitude becomes so ingrained that these persons are often thought of as being particularly "good," "decent," "nice," in fact too "nice" because of their use of very little aggression in expressing or defending their own wishes. Instead of giving vent to normal feelings of anger or hostility, they act apologetically. ("Excuse me" is their comment if you step on *their* toes.) This "retroflexion of rage" is then tied in frequently with a feeling of "omnipotence of thought," as if thoughts were real happenings, as if one's thoughts could kill. He indulges himself in a "secret life of Walter Mitty" attitude. If, then, a parent or spouse for whom he feels hate as well as love ("we can only hate when we love") suffers harm or in fact dies, the neurotic depressive blames it on himself, thinking that his thoughts were responsible. Consequently he may develop an enormous sense of guilt which in turn gives rise to a tendency to self-punishment and overpowering need for expiation.

Such a tangled knot of emotions is a challenge to any physician or psychiatrist. The patient's need is not merely palliation but the total reconstruction of his personality. Even a trained psychiatrist may find it extremely difficult to satisfy the insatiable narcissistic needs of such a person and in many instances finds it necessary therefore to refer him elsewhere. If he fails to do this but continues his efforts with the subject he may in the end lose patience and betray his feelings in a way which will only magnify the subject's constant feeling of rejection and cause him to look for help elsewhere.

These patients have tremendous needs. Even if one were to solve the immediate problem of the moment, another one soon rises up to be solved in turn. These people require long term help and are not particularly benefited by drugs.

Management Of Depression

Psychotherapy has different meanings to different observers, depending on their basic philosophy, orientation, and training. Psychiatry is moving away from the classic cartoon idea of the figure behind a couch. Psychiatrists have learned that they should act more like physicians, both in their manner with their patients and in their prescriptions. Even some orthodox psychoanalysts have been won over to the idea of using tranquilizers and mood-elevating drugs. The experience of internists, psychiatrists, and general physicians with these drugs has had an important influence on modern concepts of the physiologic events which underlie depressive states and anxiety.

Modern psychopharmacology is only about fourteen years old, beginning with the introduction of Thorazine® (chlorpromazine) in 1954. Since that time impressive advances have been made. Psychopharmacology has been one of the most important agencies for bringing medicine and psychiatry together. Most American psychiatrists have learned to leave the couch to work in hospitals and to make contact with other elements in the world of medicine instead of occupying themselves solely with the psyche of their patients three times a week. This turn of events has perhaps tended to lower the suicide rate among psychiatrists themselves, a rate which has been disturbingly high.

Management Of The Suicidal Patient

Electroconvulsive therapy is the treatment of choice in severe depressions, especially when there is a possibility or threat of suicide. This is one of the most specific treatments when properly prescribed. It is applicable in endogenous depression, involutional melancholia, senile depression and schizo-affective disorder. It is rarely useful however, in neurotic depressions, unless there is a suicidal threat. Because of its speedy effect and reliability, electroconvulsive therapy (ECT) should be given promptly to the patient who is a candidate for suicide and in this connection the physician must invariably keep in mind the possibility of suicide whenever he deals with a depressed patient.

It is desirable to make a distinction between the suicidal gesture and the suicidal attempt.

In testing the patient for any suicidal tendency the physician must listen carefully not only to what the patient says and how he says it but also to what he leaves unsaid. The patient who says, "I keep thinking of killing myself, but then, I am a Catholic and really couldn't and wouldn't want to do anything quite like that and I realize that is is a form of weakness" is probably in no greater danger. On the other hand when a patient says, "I drive my car on to the Verrazano bridge every day and stop at a certain point where I leave my car. Then I finally go back to my car," may be expressing his efforts to screw up the courage for the actual suicide act. Another patient may avoid looking at the psychiatrist directly or may murmur something about saving up some pills (e.g. barbiturates), and in this way also disclose his intention.

Suicide, especially in its hidden forms, is a far greater problem than most physicians realize In many instances, there is much uncertainty, especially when the intention is ambivalent. For example, the patient may have the wish both to live and to die. If he attempts to destroy himself his action may be inconclusive so that death may not follow the action until after considerable delay. In other instances the impulse to suicide may occur suddenly, even impulsively, and the death will then be listed as a "traffic death" caused by "loss of control of the car." And in a more subtle way many people who die of a coronary attack have in effect "worked themselves to death" because of a suicidal drive created out of their inward hostility, aggressiveness, and sense of guilt. Many alcoholics, especially weekend drinkers, are not recognized as having basically suicidal impulses. Some cases of chronic alcoholism represent essentially a form of "chronic suicide" although the death of the patient is more frequently attributed to hemorrhage from esophageal varices rather than to the patient's personality disorder. Suicide by *barbiturates* has become one of the most prevalent of all modes of self-execution. Suicide in many cases is also accomplished with the aid of liquor. The patient may take a barbiturate for his depression. Since it fails to relieve him or makes him worse, he may take a few drinks. When these two fail to help him he may take several more barbiturate pills or capsules and so on until eventually he forgets how much he has taken either of barbiturates or of alcohol. The synergism between the two is highly lethal. Barbiturates are sharply contraindicated in the treatment of any depressed person. One should treat him only with small doses of nonbarbiturates, e.g. Librium,® or Elavil,® which embody little or no suicidal risk and which do not make the depressed person more depressed, as do the barbiturates.

Drug Therapy Of Depression

The physician must familiarize himself with the effects and side effects of any drug he utilizes in practice. He selects the drug best suited for the individual patient. Dosage must be adequate for the intended purpose just as if one were to prescribe digitalis or any other drug for a given effect. Never depend upon drug therapy alone, make sure that the patient receives adequate psychotherapy and, if suicide is threatened, ECT as well.

Drug therapy cannot accomplish the magic result sought by the patient and the physician when the patient's underlying real life problem remains unsolved. Despite the brighter mood of the patient and the lessened danger of suicide, his improvement on these drugs merely serves as temporary support to make him more readily "accessible" to psychotherapy so that he can be helped to adapt more realistically to his unresolved problems and dilemmas.

Psychomotor stimulants are often of benefit in depressed people. Drugs in this class include amphetamine (Benzedrine®) and dextroamphetamine (Dexedrine®). These are in wide use but have certain undersirable side effects. Ritalin® (methylphendate) in doses of 10 milligrams every morning and every afternoon is helpful in many mild depressions. Pipradrol (Meratran®) may also be used, particularly in reactive depressions.

The MAO inhibitors (monamine oxidase inhibitors) created much excitement in this country and abroad when they were first introduced. One of the most effective was Iproniazid (Marsilid®). This drug, however, is now restricted because of a series of cases of fatal hepatitis.**

A variety of newer anti-depressant agents have been developed, e.g. Marplan® (isocarboxazid), Nardil® (phenelzine), Parnate® (tranylcypromine), or the combination of Parnate® and Stelazine,® Tofranil® (imipramine), Elavil® (amitriptyline), Deprol® (benactyzine combined with meprobamate) and many others. Side effects vary with the drug, for example, MAO inhibitors may interfere with the breakdown of tyramine, which is abundant in certain foods such as strong or aged cheeses, Chianti wine, pickled herring, and chopped chicken liver,††† resulting in severe hypertensive crises, some of which have been fatal. If a patient is given any drug which may have this type of action, particularly Parnate,® he should be warned against taking any of these foods while he is on the drug and for some time after he stops them.

A physician may be held legally liable for such side effects if he prescribes the drug to a patient 60 years of age or older or to a younger patient if some other drug than Parnate® is available which will accomplish the same therapeutic result without danger to the patient.

The selection of any drug must be guided by the target symptom which one hopes to treat. For example if one is dealing with a retarded depression (i.e. endogenous depression) Tofranil® has often been found helpful. It has been found less effective in reactive and neurotic depression. One of its side effects is the production of anxiety. For this reason it is wise to accompany the use of Trofranil® by some reliable form of tranquilizer such as Valium® or Librium® to protect the patient against the emergence of anxiety.

The dosage of Tofranil® is usually 75 milligrams a day and may be increased to 150. However, one should not expect its effect to become manifest for some period of time. Generally 4 to 6 weeks are required. This long delay in its action, even when it is going to work, suggests that that its action is upon some metabolic disorder underlying the endogenous depression, particularly in the case of the deeper forms of this depression such as is seen in people who lose appetite and weight. Tofranil® is effective in about 70 per cent of these cases without the need for ECT. An additional 20 per cent also require ECT (electroconvulsive therapy). Pertofrane,® a derivative of Tofranil,® is also an active anti-depressant and has been reported to demonstrate its effect quite rapidly, even in a few days.

In treating a depression of the cyclothymic variety, remember that this type of depression is as a rule self-limited and even when all treatments are ineffective the patient will eventually recover. If one treats such a depression on the "ascending limb of the curve," he may find that his treatment accomplishes very little. This is true even of shock therapy. To get the best result from ECT it may be better therefore to wait for some time until the depression reaches its maximal level of severity and begins to wear off. In this way one can actually help the patient with a smaller number of treatments, e.g. 3 or 4 treatments, with equally good results and with far less impairment of memory, particularly if ECT is supplemented with proper drug treatment as well. In fact if one gives the patient the usual full course of 10 treatments with ECT the effects on memory may be quite serious and in some instances permanent. One must keep this in mind, especially when one treats the conscientious goal-directed type of patient who depends upon his

** There is some evidence that these might have been cases of fulminant viral hepatitis, occuring coincidentally as part of a nation-wide epidemic of the viral infection, at the time when Marsalid® was introduced. The reaction would, then, not have been the result of the drug. The effects of this virus ranged from mild cholestatic jaundice (like that which is reported to occur with chlorpromazine) to massive necrosis of the liver, indistinguishable from what had been attributed to the Marsalid®.

††† Also canned figs and the pods of broad beans.

intellect and emotional drive, for example a physician, in contrast to the schizophrenic type of individual.

In some instances Deprol® has been found quite effective, even though its effect is milder than Tofranil.® Its action occurs quickly, which is something to be considered when one places the patient on one of the MAO inhibitors such as Marplan,® and then requires a long period of waiting before the drug can be changed to an immodibenzly derivative (Tofranil,® Elavil®).

Treatment of sleep disturbance is sometimes accomplished fairly well with two tablets of meprobamate at night. If this fails, the patient can shift to Doriden® or to some other drug. In general it is preferable not to stay with any one drug for any length of time because of the danger of addiction. In some instances two Elavil® pills (total of 50 milligrams) may give a patient a much better sleep than a barbiturate and at the same time combat his depression.

Torfranil® should be well buffered with Librium,® Elavil,® or Trilafon.® If the patient manifests an excessive tendency to aggressiveness, Tofranil® should be supplemented with chlorpromazine. In some instances the patient may require hospitalization and even electroconvulsive therapy.

(It has been reported that there is a danger in changing from MAO inhibitors to Tofranil® or Elavil® without a reasonable interval of 10 to 14 days or to use MAO inhibitors and either of these drugs in combination.)

The psychotherapy which is most effective in combination with drug treatment is often nothing more than what has been referred to as the "doctor-patient relationship." All this amounts to is being able to listen to the patient. The simplicity of this idea has ruffled the feelings of some orthodox psychoanalysts who feel that one should avoid too quick an approach through the use of drugs because this becomes a "flight into health," but should try rather to work through with the patient's problems. The effort to dig deep may unearth so much "dirt" as to create a far graver disturbance than is warranted by the patient's immediate problem. This may have been the case with many of the younger psychiatrists who became so deeply introspective with their own personal problem in the course of analysis that they were unable to continue facing life. Actually many of the "blind spots" in a person's understanding of himself may be truly protective.

A much more realistic approach would seem to be to treat the problem of the moment and not attempt to work each and every problem back to the nursery. Furthermore, the use of the drugs just mentioned has in fact been life-saving in the case of many patients who might otherwise have committed suicide. When a person is disturbed and in danger of suicide or deeply unhappy there is really no other possibility open to his doctor than to give him the necessary drug. To attempt to treat such a patient without drugs is actually medieval and, if the patient is depressed and in danger of committing suicide, to treat without drugs amounts to malpractice.

Comment

The future of psychiatry probably lies in its reintegration with medicine just as general medicine requires an increasing application of psychiatry. Psychiatrists should be on the staff of every general hospital and ideally the hospital should have its own psychiatric unit as well. Close and frequent contact between psychiatrists and general physicians has already proved its usefulness. The newer advances in our understanding of disorders of the psyche in terms of metabolism and neuroendocrinology will undoubtedly add strength to both disciplines.

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1921 Newkirk Avenue

In a surprisingly brief paper, Dr. Lewin here offers a compact monograph on repair of facial lacerations.

Management Of Facial Lacerations Due To Vehicle Accidents*

Michael L. Lewin, M.D./Paterson

Facial lacerations are common non-fatal vehicular injuries. The unstrapped front seat passenger is the most frequent victim when he is hurled forward against the windshield or the dash board on sudden stop or impact. The severity of this injury varies from a superficial abrasion or a small linear cut to extensive lacerations, avulsions, and necrosis. Any of these can be combined with fractures of the facial bones or intracranial trauma. Facial lacerations are often associated with injuries elsewhere on the body which, being more life-threatening, require more immediate attention.

Facial trauma, unlike visceral or skeletal injury, is less likely to provoke shock. The two life-threatening complications in facial and neck injuries are respiratory obstruction and hemorrhage. Both require prompt intervention. If natural air channels cannot be cleared, immediate tracheostomy is indicated. Although pressure will usually control the bleeding, large vessels should be secured. Effective management will eliminate or minimize the need for blood replacement, but consideration must be given to the total amount of blood lost from the moment of the accident.

In repair of these injuries, cosmetic considerations play an important role. Many of the victims are young people or females for whom even minor cosmetic disabilities cause severe stress and emotional repercussions.

The plastic surgeon has an important part in the management of facial injuries. As his availability increases (and the public becomes better educated) he finds himself called more often for the primary management of facial trauma. Most facial injuries are classified as minor and are taken care of in the emergency room, the majority of them attended by a general surgeon. It is important that he acquaint himself with the basic technics which are part of the plastic surgeon's routine and understand the principles of management of facial injuries as distinguished from treatment of injuries to other parts of the body.

The interest of the patient is best served if the general surgeon summons his plastic surgeon colleague when special structures, like the eyelids or nostrils, are involved or when there is distortion or loss of tissue.

The excellent blood supply of the face is responsible for the vigorous healing power, resistance to infection, and survival of tissues after traumatization. Thus, the guidelines of repair of facial lacerations differ substantially from those of treatment of wounds elsewhere on the body.

Primary definitive repair of facial lacerations can be done, if necessary, more than 24 hours after the injury. Debridement need only be minimal. Tissues of questionable vitality are likely to recover and need not be sacrificed. Preservation of tissue is imperative when deal-

*Read before the Section on Plastic and Reconstructive Surgery, Annual Meeting, The Medical Society of New Jersey, Atlantic City, May 21, 1968.

ing with specialized structures like the eyelids, nostrils, or lips. Loss of substance in such areas may require involved secondary corrections. Distorted or displaced fragments must be replaced with care and judgment. A displaced inner canthus or malaligned eyelid margin will result in severe deformity which is easier to prevent than to correct subsequently. The repair of such injuries requires familiarity with special methods, like attachment of the inner canthus to the bone, staggering of the superimposed suture lines, Z-plasty, and the like.

In many situations, primary repair, under emergency conditions, may be very tedious but will obviate more involved secondary procedures which offer a poorer prognosis.

The severance of lacrimal passages, Stensen's duct, or facial nerve deserves special attention during primary repair. The facial nerve controls the musculature of expression and its palsy results in severe deformity. Lacerations through the parotid gland will damage the pes anserina and posteriorly the main trunk of the nerve may be severed. The nerve or its branches have a better regenerative prognosis than most peripheral nerves, but this depends upon detailed surgical repair. The severed fragments can be located more easily in a fresh wound than dissected in a mass of scar tissue.

When the injuries occur outside of the vehicle, as when the passenger or driver is thrown from the car, the wounds are likely to be contaminated with foreign material. This can be handled by irrigation, scrubbing, and painstaking removal. But, if this is neglected, the resulting traumatic tattoo will be disfiguring, even if the scars remain inconspicuous. Discoloration can be eliminated only by sacrificing the involved tissues.

In severe injuries with tissue loss, mature judgment is needed to determine whether primary definitive repair is advisable. As a rule, complicated surgical maneuvers, like shifting of contiguous flaps or selective full thickness skin grafts, are neither advisable nor feasible when the surrounding tissue is damaged. Temporary split skin grafts or skin-to-mucosa suture may be preferable. This will speed up the healing, minimize shrinkage and contracture and make an early secondary repair possible and more effective.

Lacerations extending into the facial cavities (conjunctival, nasal, or oral) require careful reconstitution of the mucosal surface; otherwise, severe cosmetic and functional sequelae will ensue. Obliteration of the breathing channels, limitation of eye movements, or intraoral contractures can be more easily prevented by careful attention during the primary period than reconstructed secondarily.

Cosmetic results of facial wound repair depend on primary healing, proper alignment of tissues, repair in layers, careful hemostasis, utilization of the finest, least irritating suture material. There is never any need for heavier suture material than 5 or 6 catgut or silk. Burying of suture material may be avoided by using subcutaneous and/or subcuticular pull-out suture or 4-0 wire or nylon. Stitch marks can be prevented by early removal of sutures or by substitution of steristrips.

In spite of all these precautions, scars, after primary repair, may spread and thicken. Revision of these scars may be performed after a few months when all the induration has subsided. Sometimes children have a tendency to develop a spread scar during their growing period and a delay of secondary repair for several years may be indicated. Dermoabrasion may eliminate minor irregularities and contribute to better blending of the scar with its surrounding skin.

The cosmetic result of repair of facial scars does not depend only on the surgeon's skill. Scars differ greatly, depending on location, direction, tegumental characteristics, and other unknown factors. The scars on the eyelids are inconspicuous but broad scars tend to form on the thick, oily skin of the cheek or nose.

Time is an important factor in the improvement of scars. Fading, blending, softening and flattening of scars continues for months, if not years, after the injury. The patient must understand that scars can be improved but that no surgeon, however skilled, has magical powers to completely eliminate them.

707 Broadway

A questioning pathologist here writes of "diagnostic overkill."

Multiphasic Screening*

S. Raymond Gambino, M.D./Englewood

I am in favor of multiphasic screening. Laboratory tests are a logical extension of physical diagnosis. Laboratory tests extend and expand the physician's senses, enabling him to detect structural and functional abnormalities on the cellular and molecular level.

As is true in physical diagnosis, a great deal depends upon *how, what,* and *when.* There is no question about the need for performing multiple laboratory tests at the same time — just as there is no question that a physician who never examines a patient below the neck is a poor physician indeed!

How

Technical advances now make it possible to perform far more tests per minute than anyone dreamed of ten years ago. As a portent of what is to come, the AGA corporation of Sweden has developed an instrument that can do 24 chemistry tests on a single sample and can handle 120 samples an hour. That comes to *69,120 tests per day!* Jungnar,[1] one of the developers of this instrument, has stated that it is not really a laboratory instrument at all — it is a factory.

Unfortunately, however, instruments currently available are fixed in what they can do. Sometimes I think we are in the position of the 18th century phlebotomists. Benjamin Rush became highly proficient in bleeding patients during the Philadelphia yellow fever epidemics. He may have bled more patients per hour than the average physician — and all thought he was doing a great job. What if he had our modern technics! Think of how many more people he could have bled!

I am not convinced that more and more of what we are currently capable of doing is the right answer. Ravitch[2] has coined a term to describe what may be happening — he calls it *"diagnostic overkill."*

What

What tests should we perform? In general, we do too many of the wrong tests on the wrong people. Let us eliminate redundancy. Do the right test the right way the first time. If you went to a proctologist, you would appreciate his being able to do his job the right way the first time with a single instrument and a single trial.

The laboratory instrument that is most widely available today is the Technicon SMA-12. Some of the tests are very good and some are not good.

Good tests include: glucose, urea, uric acid, calcium, total bilirubin, total protein, alkaline phosphatase, LDH, and SGOT. These tests are good because they are usually correct and because they may detect treatable disease.

Tests that aren't quite as good because of methodology problems: cholesterol and albumin.

Tests that don't give information of much clinical value: phosphorous.

Tests that are needed but are not currently available: creatinine, iron and iron binding capacity, triglycerides, plasma cortisol, estrogens in pregnancy, metanephrines in urine for hypertension.

Other tests currently available as screening tests that do much good: papanicolaou smear of cervix, sedimentation rate, hemoglobin, smear of blood for unusual morphology, protein bound iodine or T4 (T3 not as good), and urine screen.

The urine examination is an example of what can go wrong when no real thought and at-

* Read before the Sections on Clinical Pathology and Metabolism, Annual Meeting, The Medical Society of New Jersey, Atlantic City, May 20, 1968.

tention is given to laboratory testing. The English studied the accuracy of simple test-strips and tablets applied to urines by nurses on the wards. An editorial in *Lancet* commenting on the study was entitled "Urinalysis by Oughts and Crosses" because they found that the nurses could just as well have played tick-tack-toe. The nurses didn't bother because the doctors really paid no attention to the laboratory findings.

A recent study[3] showed that physicians missed about 30 per cent of abnormal laboratory results. When all abnormal results were covered by masking tape (so the doctor had to perform a physical act to see what was underneath) the proportion of missed abnormals decreased a great deal, but — strikingly to me — there still were many results that went unnoticed!

Young[4] reported on 398 patients whose doctors were provided with more laboratory information than they would ordinarily have requested. Of the 42 patients recalled in the light of new information provided by the laboratory here is his breakdown of what was found.

4 were assigned the additional diagnosis of diabetes mellitus.

2 uremia.

1 polycystic kidney and not splenomegaly.

1 asthma and bronchitis in place of arteriosclerotic heart disease.

1 hyperparathyroidism but lost to followup.

29 significance of findings judged to be abnormal was more or less obscure. In other words, in 29 of 42 we still don't know what it all means.

When

All patients entering hospitals should have multiphasic screening, and all people who feel sick should have it too. I am not convinced that all symptom-free people should have mutiphasic screening every year. But for certain selected tests, and for certain selected population groups, annual examinations are indicated. A prime example is the cervical papanicolaou smear. On the other hand, I am not convinced that annual glucose tolerance tests are of any real benefit except for increasing our understanding of diabetes. There is a parallel in physical diagnosis.

Siegel[5] of the U.S. Department of Health, Education and Welfare has questioned the value of the periodic health examination. He insists that there is no conclusive evidence that routine examinations (after fifty years of vigorous promotion) have resulted in longer or healthier lives.

We are too ready to assume that multiphasic screening will prevent disease. Knowing that you have had a high uric acid for ten years will not prevent gout in 1968; we don't know *what* precipitates gout. We don't really know what precipates overt diabetes mellitus, and until we do, we are fooling the public when we tell them that frequent blood sugar determinations insure greater health.

Disease can be prevented more effectively and more efficiently through such public health and social measures as: population control, genetic counseling, antismoking campaigns, fluoridation, elimination of refined sugar in the diet, safer highways, safer cars, cleaner air, cleaner water, and cleaner food. If we could, for example, prevent chronic alcoholism — think of how many hospital beds we could save! We don't want to measure blood alcohol. What we need is a test that will identify those who are prone to be addicted to alcohol! Too much of what we do in the laboratory is not germane. Too much of what we do is confirmatory rather than predictive or preventive.

Disease can be ameliorated if everyone would pay more attention to the desires and needs of patients. More good would come from appointing an Ombudsman in every hospital than could come from any ten of the latest super-modern technical improvements we are so proud of.

As *Lancet*[6] has said: "In the end the aim must surely be to make early detection of alleviable disease more of a routine success

and less of an occasional piece of good fortune." This editor adds: "It should be possible to do this without allowing the overzealous screener to make a biochemical misery of our lives." This misery was eloquantly described by Gray in his "Ode on a Distant Prospect of Eton College."

Lo, in the vale of years beneath
A griesly troop are seen
The painful family of Death,
More hideous than their Queen:
This racks the joints, this fires the veins,
That every laboring sinew strains,
Those in the deeper vitals rage:
Lo, Poverty, to fill the band,
That numbs the soul with icy hand,
And slow-consuming age.

To each his suffering: all are men,
Condemn'd alike to groan;
The tender for another's pain,
The unfeeling for his own.
Yet, ah! why should they know their fate
Since sorrow never comes too late,
And happiness too swiftly flies:
Thought would destroy their paradise.
No more; — where ignorance is bliss,
'Tis folly to be wise.

350 Engle Street

ADE Is Coming

Ever since its inception in 1905 the Council on Drugs (originally the Council on Pharmacy and Chemistry) has performed a unique service for physicians by providing authoritative and unbiased information on drugs. It has adjusted its programs to keep abreast of new developments in the drug field and the changing needs of the practicing physician. The staff of this council is comprised of more than 50 persons, including 15 physicians or other scientists. The department collects, stores, evaluates, and disseminates information on drugs and cosmetics for the medical profession. Its highly specialized activities are carried out by sections on drug evaluation, drug utilization, editorial, documentation, and nomenclature.

Until 1955 the AMA's drug evaluation program was limited to those pharamaceuticals considered to have well-established clinical usefulness. It then was expanded to consider all commercially available, newer single-entity drugs. Among the past major contributions of the council have been the publications *New and Non-official Remedies, New and Non-official Drugs* and *New Drugs.*

Because of the urgent need for an authoritative, unbiased reference book that will include information on both old and new single-entity drugs and mixtures, the department is deeply involved in an extensive project to develop *AMA Drug Evaluations,* a book which will replace *New Drugs.*

Development of *ADE,* as the new publication will be called, is the most formidable task ever undertaken by the council and its staff. Its anticipated introduction sometime in 1969 will culminate seven years of planning and discussing. Currently, more than 85 per cent of the total effort of the council and the department is being directed toward readying the estimated 1,400-page book for publication. "Outside" professional help, as well as assistance from pharmaceutical information services, also is being utilized in the immense project.

Being developed by the AMA solely for the medical profession, *ADE* will provide independent, "consensus" evaluations on 1,300 drugs on the priority list which include all most commonly prescribed or used by physicians, all single-entity drugs introduced within the past 10 years and other selected drugs which have notable value, unusual toxicity, notoriety, or need for notoriety. Thorough indexing will assure maximum economy of the physician's time.

In addition, more than 4,000 other nationally distributed drugs, not individually evaluated, will be listed, indexed to give information on their therapeutic category and availability.

The care of the cancer patient has long been identified with the x-ray tube and the surgeon's knife. But medical oncology is a growing new specialty.

The Peripatetic Oncologist

Robert Lynn, M.D./Plainfield

The specialty now known as medical oncology (or medical neoplasia) is probably no older than twenty years. It had its origins and impetus with the discovery and usage of nitrogen mustard, the first alkylating agent. This is in no way to denigrate the concept of chemotherapy as first propounded by Paul Ehrlich. His concepts have also added to medical oncology but the discovery of the effects of nitrogen mustard on hemopoietic and lymphoid tissue began the experimentation with antitumor agents. Within the past twenty years the amazing quality and quantity of man power and funds channeled into cancer research have produced an astounding yield in our basic understanding of cellular kinetics and physiology. The biochemists and pharmacologists have been able to furnish us with an entirely new inventory of antitumor agents classifiable into various families of drugs with different loci of cytotoxic activity. The biochemistry and pharmacology of these chemotherapeutic agents have created the need for a new specialty in medicine termed oncology (Gr. *onkos,* tumor and *logos,* word, discourse) with experts trained not only in these disciplines but also in the pathology and natural history patterns of malignant diseases.

Equally important has been the acquisition of a unifying philosophical and psychological approach needed in the understanding of the cancer patient and his family from the social, psychological, and economic viewpoints within the community and the hospital.

The number of medical centers in the forefront of research and training in cancer can be numbered on the fingers of both hands. They are widely spread throughout the world. In these centers, the responsibility of training physicians in oncology is at least as important as the basic and clinical research. A lapse of from three to five years develops between the basic research and the clinical application within the general medical community. It is only through the training programs at these centers that the hiatus between basic research and the practical applications of research can be narrowed.

On the eastern seaboard there are only three or four centers capable of training the physician in the field of oncology — Memorial Center in New York, Francis Delafield in New York, and Roswell Park in Buffalo. These three institutions (by their very size, organization, and experience) can offer what the smaller institutions "with heart" cannot; that is: depth in exposure and experience.

The length of training as well as the nature of malignant disease eliminates many from pursuing this specialty. To cite an example, in the several years that Memorial Center has been training physicians, the total number of Memorial graduates is now approximately only 1400 physicians in *all* medical and surgical subspecialties. These graduates are from all over the globe. They often return home upon completion of their training to use their specialized skill as an important part of their medical communities.

In New Jersey and the surrounding states, oncology is practiced by doctors of varied backgrounds from the hospital pathologist, the radiologist, the general surgeon, the

hematologist, to the internist. Each is specifically suited to one modality of anti-tumor therapy with the exception of the internist specifically trained in oncology. He has working familiarity with the scope and limitation of all three of these major modalities: surgery, radiation, and chemotherapy. In the natural history of a malignancy in a patient, each of these three methods of treatment must be called into play at the proper time if cure or palliation is to be effected.

The philosophy in training an internist in medical oncology (and beyond the standard training in internal medicine) probably originated in the Medical Neoplasia Department at Memorial Hospital in New York under the guidance and leadership of two men, Craver and Diamond. Craver[1] has said that:

"The need for internists to play a large role in the study, treatment, and teaching of cancer has rapidly become widely realized in the past decade. Knowledge resulting from investigative methods and newer therapeutic agents has widened the visual field to include much more than pathology, surgery, and conventional radiation therapy. The discovery of radioactive isotopes, advances in biochemistry, explorations of chemotherapeutic agents, development of new, more powerful sources of radiant energy, the unravelling of one of the hormonal interrelationships — all these developments along with the advances in the entire field of medicine have enormously increased the scope of the cancer field. No one can now deny the value of special institutions for the study, treatment, and teaching of cancer. Essential to such institutions and indeed increasingly essential in general hospitals and in medical practice throughout the world has become the help of the internist *'dans la lutte contre le cancer'*."

One leaves a training program to practice with a certain amount of trepidation, much the way the earliest missionaries left civilization to carry the "Word" into darkest Africa. Well-armed with the truth, one can never be quite sure that the truth will ever be accepted (or even wanted) out in the wilderness. Perhaps this analogy is a bit too harsh but medical oncology as a specialty is a new concept. New concepts like tender missionaries can never be heard of again in hostile environments.

The medical community harbors a spectrum of attitudes in the non-surgical management of malignancy. These attitudes vary from concerted therapeutic nihilism to the inept use of dangerous drugs by clinicians whose familiarity of the literature begins and ends with the brochure packaged with the medication. In this latter attitude, the *primum non nocere* philosophy does not pertain because the physician feels he can do no harm in the cancer patient: "There is nothing to lose," he thinks.

The concept of cure in malignant disease is nebulous in the same way as one thinks of cure in diabetes mellitus, coronary atherosclerosis, or chronic renal disease. In dealing with the malignant disorders, we speak of palliation. Palliation is an expanding concept. The treatment of advancing neoplasia, if successful, can return the family member to an almost normal existence if even for a brief time. Patients with lymphomas can live normal lives if treated with the proper measures at the proper times. Patients with breast cancer can have successful palliative management for years or can be most effectively dispatched by their well-meaning but ineffectual practitioners because of unsuspected hypercalcemias and drug-induced myelotoxicities.

The judicious use of surgery, radiation therapy, or chemotherapy, singly, or in combination, does add normal useful time to people with admittedly serious and prognostically poor outlook diseases. This, then, is palliation. But palliation does not mean prolonged hospitalizations — rather outpatient therapies lie closer to our concept of palliation in oncology.

The role of the medical oncologist is wider than that of his responsibility to patients. With his unique training, he has a large responsibility to the rest of the medical community as well as to the general community. By his participation in civic organizations (such as the county and state chapters of the American Cancer Society) he is in a position to coordinate service programs as well as educational programs oriented to the early

[1] Graver, Lloyd. Forward in Diamond, Henry: *The Medical Management of Cancer.* New York, 1958, Brune and Stratton.

detection and prevention of cancer. Within his own hospitals[2] his participation in tumor boards and clinics, cancer registry, and conferences can add a particular dimension with his training and practical experience that the general surgeon, gynecologist, and radiologist cannot. Often his training affiliations allow him to function as a liaison between the large clinical-research centers and the community. This liaison serves an additionally important function in linking community hospitals with the numerous cooperative groups involved in clinical research in breast cancer, leukemias, and others. This also permits the trial of new and experimental agents in selective cases long before the drugs become available anywhere outside of the large center.

Thus we have essentially what industry terms as a "job specification" of the oncologist. The American Society of Clinical Oncology has established guidelines for training and accreditation in clinical oncology. It has set up special qualifications for admission into the organization. The community hospital that already can speak of the oncologist as a specialist is almost a hospital of the future.

[2] It is usually necessary for the oncologist to act as consultant on more than one hospital staff. The more progressive hospitals have realized this and will grant consultation privileges even though the oncologist does not maintain an office in the geographic community.

1314 Park Avenue

Medicare News

The SMI premium rate for the period July 1969 through June 1970 will remain at the present $4. The decision is based on the conviction that there is no need for any further increase in physicians' fees in the period immediately ahead. Former Secretary of HEW, Wilbur Cohen, has charged the Social Security Administration and the Medicare carriers to make every effort to keep payments for services in line with premium income. At the same time he promulgated the continuing $4 rate, he appealed to medical society leadership and to national business, labor, and consumer groups to give wholehearted support to efforts at restraint on both fees and utilization.

The Social Security Administration is now meeting with the carriers to determine what additional administrative steps can be taken to keep payment for services in line with the monthly income of $8 per capita derived from premiums plus the matching amount from general federal revenues.

A new open enrollment period for older people to sign up for the supplementary medical insurance part of Medicare will extend through March 31, 1969. For some — those who were born October 1, 1901 or earlier, and those who were previously enrolled, but dropped out January 1, 1967 or before — it will be the last chance to enroll. Of the population 65 and over, 95 per cent are now enrolled for the protection that helps pay doctors' and surgeons' bills, and a variety of other health care expenses.

The hospital deductible amount—the amount for which the Medicare beneficiary is responsible — increased from $40 to $44, effective January 1. Comparable 10 per cent increases are also effective in the dollar amounts a Medicare beneficiary pays toward a hospital stay of more than 60 days or for posthospital extended care of more than 20 days.

We doctors have a real responsibility for meeting the crisis in community and public health, now looming before us.

The Doctor And The Ecologic Perspective*

Roslyn Barbash, M.D./Teaneck

Why should the medical profession be involved in governmental and community health problems? In the recognizable need for a mixture of disciplines to solve environmental health problems the physician is an essential ingredient for four reasons:

As a community leader, he is called upon for information, for opinions, for guidance by patients, public officials, and legislators;

As a practitioner, he has an obligation to evaluate extrinsic factors to provide proper prophylactic and symptomatic treatment. Also, he is a source of vital data in a time when epidemiologic studies were never more needed.

As a part of the environmental health team, his help is needed to determine the adaptive capacity of man and to establish criteria to restore the environment to one in which man can thrive. And certainly his sensitivity and perception are required to reach out and discover problems. We need his foresight to forecast hazards and prevent damage.

To perform intelligently, the physician must remember that total health means more than absence of illness. Keep in mind that environmental insults of air and water pollution, noise, radiation, and overcrowding affect mental and physical well being.

The idea of single causation of disease is obsolete. Our atmosphere is limited. The cleansing capacity, overloaded by population explosion and technologic abuses, is overwhelmed. We are behind the times in coping with existing contamination. We are faced with the undetected potential damage of constantly emerging new compounds.

Everyone is affected. Unborn generations are subject to this danger. To put it bluntly, we are faced with an unprecedented crisis. To meet it, you and I must develop three attitudes:

(1) *An Ecologic Perspective* and concern for ecologic problems in which all the biota, (of which man is but one), are involved. The flow of nutrients and recycling of waste is a metabolic relation that affects *all* organisms. Man, a dominant form, has manipulated his environment, overproduced waste to his detriment, causing deterioration of his habitat. The entire fitness of our system is already at risk.

Our adaptive capacities of today are past oriented. There are differences in species adaptability, the knowledge of which have significant bearing on our strategy of environmental management. Fodder plants can tolerate fluorides but cattle, feeding on these plants, die of fluoride toxicity. We do not know our ability to adjust to the rapidity and magnitude of environmental insults that we daily encounter. Already we recognize some of the short term effects but many low-level, long term effects are as yet undetermined. Remember that even our solar energy is disrupted by air pollution. Signs of lessened

* This is a distillation of the 5th American Medical Association Congress on Environmental Health Problems — April, 1968, Chicago.

solar radiation are perceptible in climate and health. Interference with photosynthesis lessens our oxygen supply, increases carbon dioxide and causes the earth's temperature to rise. Do you know that this actually faces us with the danger of glacial melting in the not so distant future?

The advice of the ecologist must be an integral part of resource management planning. Decisions in this field in the next few decades may decide man's fate.

(2) An understanding that for existing problems there are *immediate* action goals which can be reached with available technology. You and I can give support to the standards relevant to the health and welfare of man and can be aggressive in protecting the public's health.

(3) A recognition of long range planning with special awareness of the need for a protection system that identifies emerging environmental hazards and devises measures for dealing with the needs and problems.

The value of an integrated effort in the approach to solution of the environmental problems becomes apparent in the summation of the many committee and council reports and recommendations.

We doctors are in a position to foster ecologic study in medical schools, encourage training programs in preventive medicine and dentistry, promote careers in public health and influence decision makers.

In the crucible of interdisciplinary effort, the knowledgeable, community-oriented, environmentally-aware physician is indeed an essential ingredient.

835 Red Road

OT For The Disabled

Music and games, the ancients knew, had value in the care of mental patients. The classical Greeks considered "employment . . . nature's best physician and . . . essential to human happiness." And today, the occupational therapist uses varied and often ingenious activities to help patients relearn the tasks of every day life.

A new public affairs pamphlet *Occupational Therapy—A New Life For The Disabled,* by Joel A. Levitch, provides a concise picture of this part of the rehabilitation team. It is available for 25 cents from the Public Affairs Committee, 381 Park Avenue South, New York, N.Y. 10016. Ask for brochure No. 420.

Whether he is helping a seriously damaged patient learn again to use his hands, perhaps with the aid of special equipment, or regain a lost ability or forgotten knowledge, the qualities the occupational therapist needs are understanding, sensitivity, perseverance, and ingenuity. He must complete a special academic program and clinical experience leading to either a certificate in occupational therapy or a master's degree. Through several specific cases in this pamphlet, Levitch indicates how progress is achieved through occupational therapy with patients seriously handicapped by accidents and strokes. He also explains the role of OT in the treatment of patients with neurologic disorders and of patients who are mentally retarded or emotionally disturbed.

The pamphlet concludes with a section on the requirements for occupational therapy as a career and a list of colleges and universities offering an OT curriculum.

An ectopic proliferative pancreatic malignancy is extremely rare — but here is one that appeared in the lower abdomen.

Cystic Abdominal Tumor In A 66 Year Old Man*

Julian I. Joseph, M.D., Dwarika N. Mukerjea, M.D. and, Frederick H. Kuitems, M.D./Paramus

A 66 year old man was admitted to Bergen Pines County Hospital (Paramus, New Jersey) because of vomiting of sudden onset. In the months before admission, he had noted progressive abdominal enlargement. He had poor appetite for several days and lost ten pounds in the week just prior to admission.

On admission, he had a blood pressure of 134/90. Pulse was 74 and temperature 99. He seemed emaciated and dehydrated. The abdomen was protuberant with fluid, but no local masses could be felt beyond the fluid. Flat film did not indicate an intestinal obstruction.

The laboratory reported a serum amylase of 352 Somogyi Units — normal is 80 to 180. At abdominal paracentesis, we extracted 40 milliliters of a mucinous fluid which had an amylase concentration of 50 milligrams per cent. This fluid contained large multinuclear and mononuclear cells; and in the nuclei of the former there was regularly distibuted chromatin.

Neither barium enema nor sigmoidoscopy (up to 12 centimeters) revealed anything. Laparotomy was done ten days after admission. Here we found a giant intra-abdominal cyst filling much of the peritoneal cavity and in part fused to the peritoneal lining. A portion of the cyst was retrogastric. The cyst was entered and exuded greenish jelly-like fluid. One small locule was found at an extremity of the main cyst, but the mass was essentially unilocular. Pieces of the tumorous tissue were floating free in the cyst fluid. One such tissue piece was sent for frozen section diagnosis and was read as mucinous adenocarcinoma. The cyst entry site was sutured and the lesion excised *in toto*. The cyst did not appear to emanate directly from any single viscus.

Pathologic examination revealed a cyst 30 by 23 centimeters (Figures 1 and 2), unilocular (the second locule was separately received as several small fragments), with the wall 3 to 6 millimeters thick. The surface was rough, the interior lining corrugated, and the cyst filled with mucinous fluids and floating tumorous tissue. (Total fluid separately received and in cyst amounted to 6000 cubic centimeters.) Microscopic examination (Figures 3 and 4) revealed a cyst with fibrous wall and inner lining of tall columnar mucus-containing epithelium of intestinal type but with a marked papillary pattern. The epithelium had one to several layers and in a few areas showed mitosis, disordered cell alignment, and prominent stratification. However, no areas of lymphatic permeation or definite invasion of the wall were encountered. The interior separated tissue was evidently detached papillary masses of the wall of similar histologic pattern, largely necrotic and hemorrhagic. Portions of the papillary stroma of the tumor were calcified and even ossified. Mucicarmine and toluidine blue stains were strongly positive. The histologic diagnosis was mucinous papillary cystadenoma (potentially malignant.)

Six days postoperatively the patient developed an ileus. Fecal material drained from his abdominal wound. On the 9th postoperative day, a bowel perforation was repaired and a sigmoid colostomy done. The patient died on the 16th postoperative day. Autopsy permission was refused.

This interesting cystic tumor presents two problems: (1) What is the origin of the cyst,

* This case report is from the Bergen Pines County Hospital in Paramus, New Jersey, where Dr. Joseph is Associate in Pathology, and Dr. Kuitems is Associate in Surgery. Dr. Mukerjea has a Fellowship in gastroenterology.

and (2) What is the prognosis for this lesion? We believe the tumor originated in the pancreas and subsequently became detached from it. The reasons for considering origin in the pancreas are:

(1) The histologic pattern of papillary mucinous epithelium is consistent with a proliferative cyst of the pancreas. Indeed, one region of non-papillary single-layered columnar epithelium with pale eosinophilic cytoplasm resembled pancreatic duct lining epithelium. This epithelium appeared to merge gradually with the papillary epithelium.



Figure 1: Gross
External surface of the cystic mass. Note rough character in part due to separation from attached peritoneum or abdominal wall.



Figure 2: Gross
Interior of the cyst showing gross papillations and some separated tissue pieces.

(2) The chemistries point to pancreas and pancreatic region-elevation of serum amylase, presence of some amylase in the cyst fluid, and elevation of total and direct serum bilirubin.

(3) Although not apparently emanating from the pancreas, the cyst occupied in part the region of the pancreatic bed, pushing the stomach from behind.

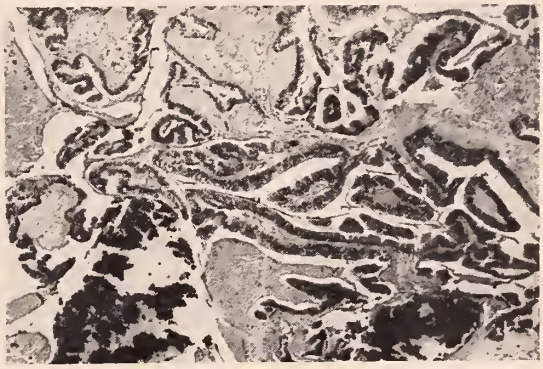


Figure 3: Microscopic, 40x, H & E
Papillary formation of the tumor just under the external fibrous wall. Note marked proliferative pattern, hemorrhage, and hyalinization of stroma.

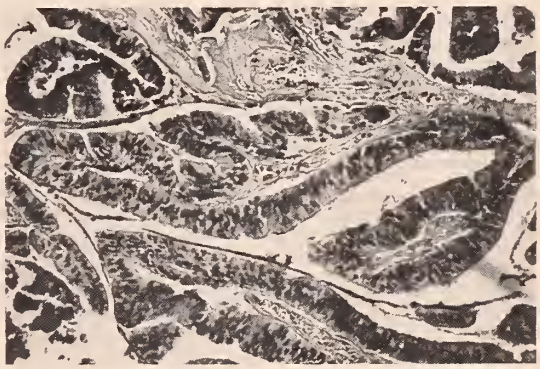


Figure 4: Microscopic, 100x, H & E
One area of mild atypism, with some cell stratification and disorder in cell alignment.

We also considered mesothelioma because of the papillary nature but excluded it because of its strong mucicarminophilia and gross cystic nature. Mucocele of the appendix with pseudomyxoma peritonei was ruled out because of the cystic nature of the lesion and location. Carcinoma of the colon was initially considered but excluded as the full gross and histologic character became evident.

Once accepting the papillary, cystic, and proliferative nature of the lesion, what should one consider the likelihood of metastatic spread? Here there was no evidence of invasion through the wall, and in large part it had a well-differentiated pattern of mucus-containing epithelium. However, some areas of the neoplasm did show a moderately advanced degree of atypism. Ovarian cystic lesions of this order of histologic atypism have been found with, at least, local metastatic spread. Is this lesion a cystadenoma with malignant potential or a cystadenomocarcinoma of borderline malignant change? Whichever nomenclature applied, we concluded that this lesion, having shown no clinical, gross, or histologic sign of invasion or metastatic spread, probably had not yet metastasized; and thus total removal would offer a chance for cure. The fusion of the cyst wall to peritoneum was due to inflammation rather than neoplastic spread.

Pancreatic cysts are of two major types: pseudocysts (derived from the effects of trauma or inflammation) and proliferative cysts which are neoplastic. Pseudocysts have no epithelial lining and contain an inflamed fibrous wall. Proliferative cysts are benign or malignant. The benign forms are cystadenomas. Sommers[1] *et al.* say that any proliferative change in the lining epithelium of pancreatic ducts represents, in itself, a premalignant state. Local proliferative changes in duct epithelium are seen with increased frequency in patients who have (a) carcinoma of the pancreas elsewhere in the gland, (b) patients with multiple primary carcinomas (exclusive of pancreatic carcinoma), and, (c) in diabetes mellitus.

Pancreatic proliferative cysts are extremely uncommon. The literature cites only a handful of cases from large institutions. Cystadenocarcinomas are even more rare. Cystadenocarcinoma may originate in a cystadenoma. Cystadenomas are usually small but are of variable size, with reports of 16 to 20 centimeters in diameter in some. Cystadenocarcinomas likewise vary in size but are probably larger on the average than the benign lesions. Treatment for proliferative pancreatic cyst is total removal. Incomplete excision leaves behind an actively secreting, growing mass with potential for malignant transformation and metastic spread.

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Bergen Pines Hospital

Colistin and Proteus Infection

In The November issue of our JOURNAL, page 586, we printed a graph (an engraving) submitted by Dr. Stanley Burrows in connection with his article, "Antibiotic Sensitivity Of Pathogenic Microorganisms." This graph showed that 91 per cent of the isolates of Proteus were sensitive to Colistin. However, Dr. Burrows advises us now that the correct figure is 9 per cent, and that the bar on the cut extended over too far. Please make this correction in your copy of the November 1968 JOURNAL.

NEW JERSEY DOCTORS' NOTEBOOK

Trustees' Minutes

January 19, 1969

A regular meeting of the Board of Trustees was held on January 19, 1969 at the Executive Offices in Trenton. Detailed minutes are on file with the secretary of your county medical society. A summary of the significant actions follows:

New Jersey Academy of Ophthalmology and Otolaryngology . . . Directed that the President of the New Jersey Academy of Ophthalmology and Otolaryngology be informed as follows – in reply to his communication to President Kustrup accusing MSNJ of "arbitrarily approving the Assembly Bill No. 102" without consulting the Academy—and that he be invited in the future to encourage the Academy to assume its proper share of responsibility and action:

1. Under the Bylaws of MSNJ (Chapter IX, Section 5) the Council on Legislation is assigned the duty of evaluating legislation – at state and national levels – proper to the interests of the Society. Its recommendations are subject to the approval of the Board of Trustees before they become the official positions of the Society.

2. In furtherance of this function, the Council on Legislation, in its solicitude for the points of view of members in the various specialties, invites all official intermediaries of New Jersey specialty societies to attend and share in the discussions indulged at all meetings of the Council at which bills of medical interest are dealt with. Copies of the advance agendas are sent to all such intermediaries, just as they are sent to all members of the Council itself.

3. The Council twice considered A-102 and voted to recommend "approval" on February 8, 1968. Subsequently, the Board received from a member of the Academy of Ophthalmology and Otolaryngology a letter setting forth objections to that recommendation. At its meeting on February 18, 1968, the Board returned A-102 to the Council for reconsideration. On March 25, the Council again studied the bill together with the submitted objections and reaffirmed its earlier recommendation of "approval." The Board approved that recommendation at its meeting on April 21. The official intermediary of the Academy of Ophthalmology and Otolaryngology did not attend either the February or March (1968) meetings of the Council on Legislation.

4. The position on A-102 of MSNJ—approval—was reported to the House of Delegates at the 1968 Annual Meeting, in Supplemental Report #1 of the Council on Legislation. The House approved it in acting upon the reports of the Council on Legislation. It was so reported in *The Journal* – Transactions Number, July 1968, page 337.

5. A-102 passed in the Assembly (66-0) on May 6, 1968. It passed in the Senate (27-0) on November 25, 1968 – after an interval of six months.

In view of all this, the Board is of the opinion that failure of the Academy of Ophthalmology and Otolaryngology to be informed concerning A-102 and to take action in furtherance of its thinking is not due to any arbitrary action or roadblocks to communication attributable to the Council on Legislation or the Board of Trustees, but rather to lack of interest and orderly cooperation in the Society's legislative process on the part of the Academy itself.

. . . Directed that a memorandum from the Chairman of the Council on Legislation be directed to representatives of the New Jersey specialty societies informing them of the problems of the Council and urging their understanding and continuing cooperation in the furtherance of the Society's legislative goals.

New Jersey Chamber of Commerce . . . Authorized Dr. John J. Bedrick of Bayonne and Dr. Louis K. Collins of Glassboro (with expenses paid) to represent MSNJ at the 32nd Annual Reception and Dinner Meeting for members of the United States Senate and House of Representatives, sponsored by the New Jersey State Chamber of Commerce, February 6, 1969 in Washington, D.C.

AMA Congress on Medical Education . . . Authorized the attendance of the Chairman of the Committee on Medical Education, Dr. Louis F. Albright, (with expenses paid) at the 65th Annual Congress on Medical Education, February 6 to 11, 1969 in Chicago.

Joint Commission on Accreditation of Hospitals . . . Authorized the attendance of Dr. Louis F. Albright and Dr. Sherman Garrison

(with expenses paid) at a meeting between state medical association representatives and the AMA Commissioners to the Joint Commission on Accreditation of Hospitals on February 10, 1969 at the AMA headquarters, preparatory to the meeting with this group and the staff of the Commission on February 11, 1969 in Chicago to review and discuss the revised standards for hospital accreditation prior to their final adoption by the Commission.

National Conference on Nursing . . . Designated the Chairman of the Committee on Nursing Education and Recruitment, Dr. Jesse McCall, to attend (with expenses paid by the AMA) the National Conference on Nursing, April 11 and 12, 1969 in Chicago.

New Jersey Regional Medical Program . . . Agreed to cosponsor (with no financial commitment), with the New Jersey Regional Medical Program, a tutorial session for hospital administrators, medical record librarians, and key physicians (designated by individual hospitals) whose responsibilities include medical records, utilization review, and similar activities, April 17, 1969 in North Brunswick. The program will be conducted by the Commission on Professional and Hospital Activities of Ann Arbor, Michigan.

Interagency Committee for Education of the Handicapped . . . Directed that the Commissioner of Health (in response to his request for MSNJ's official position) be informed of the Society's approval (in accord with the approval of the MSNJ Committee on Occupational Health, Workmen's Compensation, and Rehabilitation, and the Council on Medical Services) of the report of the Interagency Committee for Education of the Handicapped.

Conference on Encephalitis . . . Authorized the Society's cosponsorship, with the New Jersey Public Health Association, of a conference on April 23, 1969 in North Brunswick, to appraise what can be done to eliminate or lessen the threat of mosquitoborne illnesses being transmitted to humans.

Air Pollution Control . . . Authorized the Chairman of the Committee on Air Pollution Control, Dr. Roslyn Barbash, to arrange for MSNJ representation at public hearings on air pollution control.

Corneal Tonometric Examinations by Optometrists . . . Referred to the Society's Acting Legal Counsel the following recommendation from the Committee on Conservation of Vision, with the request that an outline for alternative steps be available for the February meeting of the Board:

That the Board of Trustees take whatever steps are necessary in the protection of the public interest to assure that only licensed medical practitioners and their legally authorized assistants be permitted to use drugs in examining eyes.

(The above recommendation is the result of an informal opinion to the Board of Medical Examiners by a Deputy Attorney General that an optometrist may legally perform corneal tonometric examinations and in the process instill anesthetic drops into the eye, which the Committee believes is an invasion of the Medical Practice Act.)

. . . Referred correspondence from the Middlesex County Medical Society concerning a similar recommendation to Acting Legal Counsel for evaluation and report to the Board.

Amblyopia Screening Program . . . Approved the following recommendation from the Committee on Conservation of Vision: (The New Jersey Commission for the Blind has formed an advisory committee consisting of representatives of Service Clubs, PTA's, nurses, civic leaders, and an optometrist in connection with the Amblyopia Program.)

That the revised protocol of the Amblyopia Program conducted by the New Jersey State Commission for the Blind be approved by the Council on Public Health, and subsequently by the Board of Trustees, and that it be officially endorsed by the Medical Society of New Jersey.

Emergency Room Training For Physicians . . . Approved the following recommendations from the Committee on Emergency Medical Care: (The Division of Emergency Medical Services of the United States Public Health Service will be able to appropriate up to $2,500 and provide one or more instructors for the course.)

1. That MSNJ sponsor a training program for emergency room physicians and any other interested licensed practitioners, and that the subject matter be of such nature as normally is recommended for emergency room physicians.

2. That this training course be given on successive Wednesdays so that it would be convenient for the majority of physicians to attend, since the training will take two days.

3. That the training programs be presented in the five judicial districts of MSNJ.

Project Hope and Viet Nam . . . Approved a recommendation from the Committee on Project Hope and Viet Nam that a $1,000 fellowship be given to James R. Wiant, M.D. of Hunterdon County immediately for his tour of duty in Viet Nam, scheduled for January 27 to March 27, 1969.

AMA Congress on Socio-Economics of Health Care . . . Authorized the attendance of Dr. John J. Bedrick of Bayonne as MSNJ's representative at the AMA Third National Congress on Socio-Economics of Health Care, March 28 and 29, 1969 in Chicago.

Medicaid . . . Designated Dr. John F. Kustrup (as President of the Society and Chairman of the Society's Negotiating Committee for Medicaid) to present a statement in behalf of MSNJ at a public hearing to be held at the direction of the State Medicaid Commission on the question of method of payment under New Jersey's Medicaid Program, January 28, 1969 in Trenton.

Meeting Attendance . . . Directed that a letter, over the signature of the President, be sent to all members of councils and committees against whom one unexcused absence has been recorded, indicating that one further unexcused absence will be construed as an automatic vacating of his position on the council or committee.

Classification of Membership . . . Referred correspondence from the Hudson County Medical Society, concerning a resolution urging MSNJ not to adopt the type and classification of membership recommended by the Board of Trustees of the AMA, to the Committee on Revision of Constitution and By-laws.

Acceptance of Bank Cards

Throughout the country there is a growing interest in the acceptance of bank credit cards for the financing of medical fees. The AMA Judicial Council has taken the following position on this, concurred in by the Judicial Council of MSNJ on July 24, 1968. It is here reprinted at the direction of the Board of Trustees — January 18, 1969 meeting.

The Judicial Council is of the opinion, at this time, that physician participation in bank card programs is not *per se* unethical. It is of the opinion that physicians may ethically accept bank cards in the payment of current medical bills in lieu of cash or check, that is, as a medium of exchange.

The use of bank cards in financing medical fees must, however, be viewed with reserve at the present stage of their development. While patients may not be denied the right to determine matters of their personal budgeting, physicians must not encourage the use of this financing method if in operation it might compromise the ideals of the medical profession or add to the financial burden of patients.

In connection with physician participation in bank card programs, the Judicial Council recommends the following principles to be implemented and applied as necessary by the county medical society for the guidance of physicians as these programs develop.

1. The county medical society should be satisfied as to the financial and professional integrity of the plan. It should negotiate with the plan sponsors to insure that service charges to the physician are reasonable. It should insist that the plan be open to all physicians on the same terms and that it not exploit or capitalize on physicians' participation in the plan. It should advise the plan that the listing of physicians in directories of participating members is contrary to the ethics of the medical profession.

2. The individual physician may not, because of his participation, increase his fee for medical service rendered the patient. He may not use the plan to solicit patients. He may not encourage patients to use the plan. His position must be that he accepts the plan as a convenience to patients who desire to use it. Plaques or other devices indicating participation in the plan within the physician's office shall be kept to a discreet and dignified minimum. Plaques, signs, or other devices indicating such participation visible outside the physician's office are unacceptable.

3. The use of a bank card in connection with the payment of larger fees — which might normally be paid to the physician in installments — is not to be encouraged. All members of the Association are expected to continue the traditional practice of permitting patients of limited means to pay relatively large fees in installments without interest or carrying charges. Out of respect for the dignity and traditions of the medical profession, the physician may not relieve himself of his obligations "to render service to humanity, reward or financial gain being a subordinate consideration."

Communicable Diseases In New Jersey

The following communicable diseases were reported to the Division of Preventable Diseases during January 1969:

	January 1969	*January 1968*
Aseptic Meningitis	2	4
Primary Encephalitis	1	0
Post-Infectious Encephalitis	0	1
Hepatitis: Total	141	147
Infectious	122	121
Serum	19	26
Malaria		
Military	0	8
Civilian	1	1
Meningococcal Meningitis	19	2
Mumps	176	761
German Measles	26	36
Measles	58	34
Salmonella	10	43
Shigella	0	8

Influenza

As January ended, the influenza outbreak appears to have waned. Results of a small telephone survey showed that the peak of influenza came about the last week in December. "Flu-like" illness was reported from 19 of 21 counties and Influenza A2/Hong Kong/68 was confirmed in the following counties: (order is in sequence of documentation) Burlington, Camden, Mercer, Atlantic, Middlesex, Morris, Somerset, Essex. Gloucester, Salem, Cumberland, Passaic, Monmouth, Bergen, Union, Hudson and Warren.

The epidemic began in South-Central New Jersey and then spread north to the metropolitan areas. This is in contrast to Influenza A2 during 1967-68 which began in the metropolitan area and spread south.

Twenty-eight cases of influenza were confirmed, serologically or *via* virus isolation, in people who had complications such as pneumonia and congestive heart failure. Eight of these people died. The ages of these eight varied from 3½ to 88 years with three over 50. Many of these patients had some underlying illness and developed pneumonia or congestive heart failure as a complication to acute influenza.

Aseptic Meningitis

During 1968, 360 cases of aseptic meningitis were reported. The peak occurred in July, August, and September when 60, 132, and 71 cases respectively were reported. In a group of 46 cases serologically or *via* viral isolation the predominate agents were: Echo 9 (41 per cent), Mumps (28 per cent) and Coxsackie B3 (15 per cent). There was a predominance of males particularly in the 5 to 9 year old age group.

During 1967 only 146 cases were reported. The increase in the number of cases reported in 1968 is probably because of better reporting by doctors and hospitals, partly due to the publicity of the eastern encephalitis outbreak.

Encephalitis

Fifty-nine cases of encephalitis were reported to the State Health Department during 1968. The etiology was as follows:

Herpes Simplex	—	5
Eastern Equine	—	12
Post Infectious Varicella	—	2
Primary Type Unknown	—	40
		59

Salmonellosis

Approximately 640 confirmed cases of salmonellosis in New Jersey residents were reported during 1968. This figure is nearly 12 per cent greater than the anticipated incidence of 570 cases, based on the average for the previous five years. Greater diagnostic efforts on the part of physicians, hospitals, and laboratories probably contributed to the rise, but there is also an increase in the actual number of sporadic cases. The incidence of one serotype in particular, *S. typhimurium*, has risen more than 50 per cent over the previous annual five year average.

At least six deaths were attributed to salmonella. Two were reported here last month, in adults, ages 17 years and 56 years, subsequent to eating a heavily infected Thanks-

giving dinner. Another adult, age 68, two infants and a 3 year old, all normal otherwise, expired during the acute stage of illness with this disease. It also precipitated a fatal outcome of at least three others who had underlying problems.

Project HOPE

Fellowships for a tour of duty on the S.S. HOPE are available to physicians through The Medical Society of New Jersey, carrying a stipend of $1,000 for a sixty-day tour. Donations, which are tax deductible, may be sent to Project HOPE, 2233 Wisconsin Avenue NW, Washington, D.C. 20007.

William B. Walsh, M.D., commenting on this project, writes in the January 1969 *Newsletter* of our Burlington County Medical Society:

In March 1968, the S. S. HOPE sailed for Ceylon. Other HOPE shorebased programs continued in Nicaragua, in Quito and Guayaquil in Ecuador, and in northern Peru. An additional facet of helping people to help themselves has been the exchange program between the University of Cartagena in Colombia and the University of Trujillo in Peru. This demonstrates more than ever HOPE's philosophy to give those whom we help a belief in their own ability to solve local problems.

In shorebased educational programs in Latin America, stress has been placed upon the training of auxiliary medical personnel. The Nursing School of the University of Trujillo, initiated at the request of the University by Project HOPE personnel three years ago, graduated its first class this year. Peruvian nursing instructors are now being absorbed into the facility, and within a year this entire school will be under the supervision of Peruvian nursing educators. The former dean of the University of Trujillo Medical School has become a member of our permanent educational staff and is coordinating educational activities for Project HOPE in Peru.

In Colombia significant advances this past year have been in administraton, nurses training, and technical education. Our public health coordinator has been successful in the development of a strong department of preventive medicine at the University of Cartagena and the expansion of a community health program. This has included the participation of a dental health educator supplied by Project HOPE. The Colombian community continues to provide the support for housing the large number of personnel we have in that country and is anxious to expand our teaching training relationship even further.

In Ecuador we joined forces with the Saint Louis University in the support of a nursing education program at the university in Quito. In Guayaquil a nutrition education program continues to receive top priority. Technical training, particularly in physical therapy and rehabilitation, has moved forward and the local university is anxious now to establish a department for this field in the university with our help.

In Nicaragua, our unit continues to supply guidance at the medical educational level as well as in nurses' training and the improvement of the laboratory program at the university.

Our mission to Ceylon is now entering its final months. The teaching staff has become the largest in our history. There are 162 members of this staff representing HOPE in that island nation. The activities both on board ship and ashore should be greatly facilitated since the bulk of the personnel with whom we are dealing speak English. This is our first experience in an English-speaking country, and communication problems are minimal. The quality of our volunteers continues to be high, and our problem is not staffing as much as selection. Because of the distances involved and the size of the mission, costs are 20 per cent higher than past years, but the results will merit the investment. The unit at Kandy is operating as virtually an independent subsidiary of the

ship's unit, since it is in the mountains some seventy miles away from our berth. It is under the direction of a full-time medical educator, and this is one of the really successful parts of this mission.

In the course of the past year we have fulfilled our promise of bringing HOPE and the ability to help themselves to millions on three continents. The knowledge that there are many like the wonderful people of our HOPE staff at home and abroad, dedicated to brightening the opportunities for progress, is in itself a catalyst to their dreams. There is no such thing as an impossible dream. Faith in one's fellowman and faith in one's self to know what is right — these things give us the courage to bring HOPE to so many.

The Brave New World Of The Computer

Even the patients now can be monitored.

The Medical College of Georgia and the National Cash Register Company together have developed a computerized system for monitoring and analyzing the incidence of communicable diseases within a community. The system is the product of two man-years of programing effort.

Under the direction of Dr. Rufus F. Payne, the Medical College's Division of Hospital Research and Development is actively exploring the application of the computer to the solution of medical problems. Current projects include:

1. The development of a medical audit system for hospitals. The computer will analyze the utilization of facilities, the quality of care, the value of established procedures, the effectiveness of antibiotics under different conditions and the normal delays in making space available for different groups of patients.

2. The development of computerized medical records for out-patients of a hospital or large clinic. These records will provide any staff physician or dentist who must refer to them a current and comprehensive picture of the patient's condition.

3. A complete, long range and large scale patient information system for hospitals.

4. A control system for long term management of any type of patient. This is particularly useful in communicable disease control. It is currently in operation in Richmond County (Augusta), Georgia and Aiken, South Carolina, with records now being abstracted for the inclusion of patients in other nearby counties.

Under the system, every person who is identified as having experienced some degree of risk, either in terms of contact or of actual disease, is registered by the Control Registrar. The basic information on each patient is written in a form which organizes it for entry through punched cards into the computer. Filling the form requires two minutes for a new case and an average of ten minutes for a case with a treatment history. This information is in the computer's magnetic file for review and analysis.

The computer prepares new case and contact report lists and investigation requests on a weekly basis. These listings are sent to investigators responsible for locating and investigating new cases.

After a case has been entered into the system, action is begun to relieve the patient and protect his contacts. Appointment letters are actually written by the computer. These even include periodic reminders of regular checks-ups once the patient begins treatment. As the letters are written, schedules are established. All data pertinent to examination, treatment, and drug scheduling is stored in the magnetic files. If the forms provided to the clinic for the recording of test results, treatments, and drug prescriptions are not returned within the stipulated time, the system reports the patient as delinquent.

Under a manual system, the scheduling of tests and examinations is a tedious operation requiring the attention of a medically competent individual, usually a doctor or a nurse. A clinic nurse may spend 20 per cent of her time reviewing records. But under this electronic system, the computer can review and update 500 patient records — including the preparation of schedules and the writing of the appointment letters and reports on the 500 patients — all within 12 minutes. The system frees the doctor or nurse for more de-

manding medical functions. Furthermore, the computer applies a rigid set of criteria to produce consistent results under all conditions.

The system is not inflexible. The physician always has the option of altering or canceling the computer generated schedule by manual scheduling when he feels he should.

After a patient keeps an appointment, the treatment center enters the results in the turn-around documents provided by the computer center. Any change in status, stage of disease, treatment rendered, x-ray results, laboratory results, drug pick-up, type of drug and quantity dispensed, next appointment date, or other information pertinent to treatment and cure are entered in the appropriate forms and returned for entry into the computer. This information is used to update the records in the magnetic file. The system supplements the action documents, such as the appointment letters, with the management reports needed for direction and enforcement. For example, the computer automatically checks the appointment portion of each patient's record and accumulates the information necessary to print out a delinquency list for remedial action. A status change which results in the discharge of the patient triggers the transfer of his records from the active file to printed registers and off-line magnetic storage for later research, special surveys, and other studies. Laboratory results, x-ray reports, and other tests generate letters to the patient and his physician. Drug usage is calculated from the amount previously dispensed and the exhaustion date to determine if the patient takes the drugs as prescribed. If he does not, his name is included in a report so that steps can be taken to explain the necessity for more rigid adherence to the treatment program established for him.

The system developed by Dr. Payne and NCR for the control of communicable diseases is written for an NCR 315 data processing system with a minimum of four tape handlers and a 10K memory.

203rd Annual Meeting
The Medical Society of New Jersey
May 17-20, 1969
Haddon Hall, Atlantic City

Program Outline

Friday, May 16, 1969

4:00 p.m. — Board of Trustees
7:00 p.m. — Buffet Dinner

Saturday, May 17, 1969

10:00 a.m. — Registration Opens
1:00 p.m. — Golden Merit Award Ceremony followed by Reception for GMA Recipients and their families
3:00 p.m. — House of Delegates and President's Farewell Address
4:30 p.m. — Nominating Committee
7:00 p.m. — Officers' Dinner

Sunday, May 18, 1969

9:00 a.m. — Registration Opens
9:30 a.m. — Special Scientific Sessions
10:00 a.m. — Exhibits open
10:00 a.m. — Coffee-meeting with Reference Committee Chairmen
10:45 a.m. — Reference Committees
2:00 p.m. — Motion Picture Theatre
2:30 p.m. — House of Delegates (election)
4:00 p.m. — Inauguration of Incoming President followed by General Session
6:00 p.m. — Inaugural Reception
8:00 p.m. — Exhibitors' Reception-Buffet

Monday, May 19, 1969

9:00 a.m. — Registration and Exhibits open
10:00 a.m. — Motion Picture Theatre
All Day — Scientific Sessions (MSNJ)
2:00 p.m. — Motion Picture Theatre
7:00 p.m. — Annual Dinner-Dance

Tuesday, May 20, 1969

9:00 a.m. — Registration and Exhibits open
9:00 a.m. — House of Delegates
10:00 a.m. — Motion Picture Theatre
All Day — Scientific Sessions (MSNJ)
2:00 p.m. — Motion Picture Theatre
5:00 p.m. — Exhibits and Registration Close

Wednesday, May 21, 1969

8:30 a.m. — Board of Trustees

ANNOUNCEMENTS

How to Determine Disability

Under the chairmanship of Dr. Jarvis Smith, the afternoon of Wednesday, April 16, will be devoted to a practical seminar on disability determination. This should be part of every physician's job, but too many doctors pay too little attention to it. The colloquium will be held in East Brunswick at the Brunswick Inn which is located at Turnpike Exit 9 (at its intersection with route 18).

Actually this meeting is in celebration of the 50th anniversary of the New Jersey Rehabilitation Commission. It starts with a luncheon and this will be followed by a program on *Criteria for Disability Evaluation,* presented by the Disability Determination Service. Included will be an open discussion on the criteria for disability adjudication used by the Social Security Administration in its disability benefits program. Workshops will be held with "CPC type" meetings.

Reservations are necessary (luncheon is free), and may be made by writing to Eric Wolf, M.D., Disability Determinations Service, Room 307 at 1100 Raymond Boulevard, Newark, New Jersey 07102.

Graduate Course For School Physicians

This year the New Jersey School Physicians Association has selected two topics of intimate interest to all of us. One is on the use of psychedelic drugs, and the other concerns the economics of school health programs. The workshop will begin on April 23, and subsequent sessions will be on April 30 and May 7. The meetings will be held at the Labor Relations Education Center at Rutgers University, Ryder's Lane, New Brunswick, off Route 1, just south of Route 18. The sessions are open to physicians, school nurses and coaches. For further details, write to Thomas P. McFarland, M.D., 110 West Main Street, Mays Landing, New Jersey 08330.

Symposium On Sigmoidoscopy

On Wednesday, May 7, the Pennsylvania Society of Colon and Rectal Surgery will present a symposium on sigmoidoscopic technic in diagnosis and treatment. The panel, which includes one of New Jersey's prominent proctologists, Dr. George L. Becker, Sr. of Paterson, will discuss preparation of the patient, indications and contraindications, hazards of the examination, the prevention of complications, and biopsy and fulguration technic. Two brief papers will be given prior to the symposium — one on the management of perineal pain, and the other on inverted diverticulum of the colon. The program, which will be held at the Union League, Broad and Sansom Streets, Philadelphia, begins at 5:30 p.m. It will be followed by a reception and dinner. For reservations, please send your check for $12.50 (payable to The Pennsylvania Society of Colon and Rectal Surgery) to Valentine R. Manning, Jr., M.D., 3336 Aldine Street, Philadelphia 19136.

Contact Lens Seminar

The annual advanced seminar on contact lens technics, sponsored by the New York Eye and Ear Infirmary, will be held Saturday, May 24, 1969 at the Infirmary, 310 East 14th Street, New York. The morning session will be devoted to discussions of soft lenses and aphakia. The afternoon meeting will cover methods of fitting keratoconus, corneal grafts, astigmats, and astigmats and children. A star-studded faculty of speakers has agreed to be on the platform.

The $50 fee includes registration, tuition, luncheon, and a cocktail reception. For more information or reservation, write to Jane Stark, Registrar, Post-Graduate Institute, New York Eye and Ear Infirmary, 310 East 14th Street, New York 10003.

OBITUARIES

Dr. Charles C. Fenech

One of our state's best known medical scientists died in Arizona on January 2, 1969. He was Charles C. Fenech, M.D., born in 1895, who won his M.D. at Fordham in 1921. Before it was fashionable to do so, he went to Vienna in the 1930s, doing graduate work in basic medical physiology. He was active in postgraduate education and had a term as president of the American Medical Association's group in Vienna in 1936. While practicing in New Jersey, Dr. Fenech was affiliated with St. Michael's Hospital in Newark, and St. Mary's in Orange.

Dr. Andrew F. Ferrari

Andrew F. Ferrari, M.D., a member of our Bergen County Medical Society, died on December 17, 1968. Dr. Ferrari was a graduate of the Medical College of the University of Loyola in 1932. He practiced in Hohokus as a family doctor and was an active member of the American Academy of General Practice.

Dr. Edward J. Finnerty

At the early age of 41, death came suddenly to Edward James Finnerty, M.D., a member of our Camden County Medical Society. Born in 1929, Dr. Finnerty won his M.D. at the Hahnemann Medical College in 1961. On being graduated from medical school, he obtained a commission in the U.S. Navy and served as a medical officer for two years. After resuming civilian status, he was appointed as the industrial physician for civilian employees at the Philadelphia Navy Yard. Dr. Finnerty died on January 20, 1969.

Dr. George J. Holmes

Senior members of The Medical Society of New Jersey will remember with affection the activities of George J. Holmes, M.D., who died on December 29, 1968. Born in 1877, Dr. Holmes received his M.D. at Columbia University's College of Physicians and Surgeons in 1900. He was one of the pioneers in school medical practice, but his major field of interest was in eye and ear, nose, and throat work — at a time when these two specialties were often merged. He received the Golden Merit Award at the 1957 Annual Meeting of MSNJ. During his period of active practice, Dr. Holmes was affiliated with St. Barnabas Hospital in Livingston, and the Newark Eye and Ear Infirmary.

Dr. Eugene T. Kennedy

One of Passaic County's well known general practitioners and family physicians died on Christmas Day, 1968, with the passing that day of Eugene T. Kennedy, M.D. Born in 1902, he was a graduate of the Medical School of Temple University in 1928. He was affiliated with the St. Joseph Hospital in Paterson.

Dr. Frederick J. Koelsch

Word has just been received of the death, in California, of Dr. Frederick J. Koelsch, M.D., a well-known Middlesex County surgeon. Dr. Koelsch retired and went to live in California some years ago. He received his medical degree at McGill in 1929 and was affiliated with both New Brunswick hospitals at the time of his retirement. He served as a medical officer in the U.S. Navy during World War II. Dr. Koelsch, who was born in 1895, was 73 years old at the time of his death on November 11, 1968.

Dr. Julius Levy

Julius Levy, M.D., one of the country's pioneer pediatricians, died on January 24, 1969 at the age of 87. A Princeton graduate, class of 1900, he received his M.D. in 1904 at Columbia University's College of Physicians and Surgeons. After interning at Orange Memorial, he went briefly into general practice and then began to concern himself with the almost brand new specialty of pediatrics. From the beginning, he was a trail blazer here, seeing that the medical care of children was not just a matter of medication and infection, but also a problem in social controls and human relations. In 1913 Newark's Health Department established

a Child Hygiene Division, and Julius Levy was named to organize and operate it. Five years later, our State Department created a Maternal and Child Health Bureau, and he was again asked to develop and run it. When the New Jersey Academy of Medicine was founded, Julius Levy was in the small charter group that established it. When the American Board of Preventive Medicine and Public Health was created, Julius Levy was in the elite group of doctors who set it up.

Medicine, he always said, was a social science, and his insistence on this concept was responsible for early efforts to establish racial integration in medical practice. Long before a recognition of the rights of Negroes had become fashionable, Julius Levy was active in the struggle to give meaning to the concept of the brotherhood of man.

Dr. Frank P. Nicholson

On December 25, 1968, one of Hudson County's senior otolaryngoloists died. He was Frank P. Nicholson, M.D., who had retired some years ago to his home in Sea Girt, New Jersey. Dr. Nicholson was one of the recipients of the Golden Merit Awards presented at the 1966 Annual Meeting of MSNJ. He received his M.D. from the University of Maryland in 1916. Dr. Nicholson had been associated with the St. Francis Hospital in Jersey City.

Dr. Thomas L. Pellett

The Sussex County Medical Society has announced the death, on December 10, 1968, of one of its oldest members, Thomas L. Pellett, M.D., who was 73 years old at the time of his death. Dr. Pellett was a surgeon who had been on the staff of both the Alexander Linn Hospital in Sussex, and the Franklin Hospital in Franklin. He was a 1961 laureate of The Medical Society of New Jersey's Golden Merit Award. Dr. Pellett was a graduate of the Medical School of the University of Pennsylvania in 1911.

Dr. Irving E. Rineberg

Announcement is made of the death on May 12, 1968 of Irving E. Rineberg. Word of this event has just reached The Medical Society office. Dr. Rineberg was born in 1904 and was 64 years old at the time of his death. He was in the class of 1930 at the Medical School of the University of Maryland. Dr. Rineberg was an orthopedic surgeon, especially interested in rehabilitation surgery, and was active in the Rehabilitation Hospital at North Brunswick. He was on the orthopedic service at both Middlesex General and St. Peter's Hospitals in New Brunswick. He was on active duty with the U.S. Navy in 1944 and 1945.

Dr. Herman Schorr

Word has just been received of the death on March 11, 1968 of Herman Schorr, M.D., an emeritus member of the Hudson County Medical Society and a Golden Merit Award Laureate of The Medical Society of New Jersey. Born on October 17, 1889, he received his M.D. at Cornell in 1910. Since he had not yet attained the minimum licensing age of 21, he had to wait until the end of his internship to acquire a New Jersey license. Dr. Schorr was an "all around physician," of the species they apparently don't make any more. He was, for example, much interested in psychiatry in the days before that was a well defined specialty, and he served the New York State courts in the 1920s as an expert on criminal responsibility. (In those days he was called an "alienist.") Dr. Schorr was also much interested in nutrition and metabolism, and was a real pioneer in the development of soybean flour as food. And with all these interests, he was also a competent surgeon. It was a full and useful lifetime.

Dr. Dominic V. Vitale

Announcement is made of the death on January 11, 1969 of Dominic V. Vitale, M.D. of Elizabeth. Dr. Vitale was born in 1896 and received his M.D. from Georgetown University Medical School in 1922. Dr. Vitale was a specialist in the fields of ophthalmology and otology, and was a consulting surgeon in otology at St. Elizabeth's Hospital, and senior attending at the Alexian Brothers Hospital. Dr. was active in the affairs of the Union County Medical Society.

MEETINGS OF MEDICAL INTEREST

This listing has been compiled by the Academy of Medicine of New Jersey. For additional information, including exact time of meetings, write to the society or hospital listed.

1969
March

7-9 **The Academy of Medicine of New Jersey and Bergen Pines County Hospital**
Marriott Motor Inn
Saddle River
"Current Concepts in Respiratory Disease"

11 **Bergen County Medical Society**

12 **Gloucester County Tuberculosis and Health Association**

12 **Mercer County Medical Society**
State Hospital
Trenton

12 **Middlesex County Medical Society**

12 **Ocean County Medical Society**

12 **Bergen Pines County Hospital**
Division of Internal Medicine
Paramus
"Gout and Uric Acid Metabolism"

12 **The Academy of Medicine of New Jersey, American Academy of General Practice, and Middlesex General Hospital**
Middlesex General Hospital
New Brunswick
"Mechanisms and Treatment of Shock"

12 **The Academy of Medicine of New Jersey**
Section on Basic Medical Sciences
Symposium
Rutgers, Newark
Symposium: "Drugs and Metabolism"

19 **The Academy of Medicine of New Jersey**
Muhlenberg Hospital
Plainfield
Symposium: "Management of Gastrointestinal Hemorrhage"

19 **Bergen Pines County Hospital**
Division of Internal Medicine
Paramus
"Acute Leukemia"

19 **The Academy of Medicine of New Jersey**
Helene Fuld Hospital
Trenton
Symposium: "The Treatment of Shock"

19 **The Academy of Medicine of New Jersey, American Academy of General Practice, and Middlesex General Hospital**
Middlesex General Hospital
New Brunswick
"Recent Development in Management of Cardiac Emergencies"

20 **Gloucester County Medical Society**

20 **Morris County Medical Society**

20 **Essex and Morris County Medical Societies with Sandoz Pharmaceuticals**
Sandoz Auditorium
Hanover
"Rheumatic Fever: Diagnosis and Treatment"

25 **Hunterdon County Medical Society**

26 **Bergen Pines County Hospital**
Division of Internal Medicine
Paramus
"Diuretic Agents and Therapy"

26 **The Academy of Medicine of New Jersey and Roosevelt Hospital**
Roosevelt Hospital
Metuchen
"Pulmonary Diseases"

26 **New Jersey Gastroenterological Society**
St. Joseph's Hospital
Paterson
Regional Meeting

26 **The Academy of Medicine of New Jersey, American Academy of General Practice, and Middlesex General Hospital**
Middlesex General Hospital
New Brunswick
"Benign and Malignant Hypertension"

31 **Cape May County Medical Society**

April

1 **Hudson County Medical Society**
"Changes In Medical Care and Practice"

2 **The Academy of Medicine of New Jersey**
Section on Obstetrics and Gynecology
Symposium: "Gynecological Neoplasms"

2 **Bergen Pines County Hospital**
Division of Internal Medicine
Paramus
"Chronic IPT — Pathogenesis and Management"

8 **Bergen County Medical Society**

8 **Cumberland County Medical Society**

9 **Gloucester County Tuberculosis and Health Association**

9 **Mercer County Medical Society**
State Hospital
Trenton

9 **Middlesex County Medical Society**

9 **Ocean County Medical Society**

12 **Kessler Institute For Rehabilitation**
Pleasant Valley Way
West Orange
"Congenital Amputee Clinic" (9 a.m. to noon)

15 **Warren County Medical Society**

16 **New Jersey Rehabilitation Commission Golden Jubilee Celebration**
Brunswick Inn
East Brunswick
Luncheon, followed by program on "Criteria for Disability Evaluation"

16 **Essex and Morris County Medical Societies with Sandoz Pharmaceuticals**
Sandoz Auditorium
Hanover
"Treatment and Management of Puberty, Pimples, and Adolescence"

16 **The Academy of Medicine of New Jersey**
Hoffman-LaRoche
Nutley
Symposium: "The Management of Urinary Tract Infections"

16 **The Academy of Medicine of New Jersey**
Section on Dentistry
VA Hospital, East Orange
Symposium: "The Dentist's Role In Facial Pain And Its Management"

17 **Gloucester County Medical Society**

17 **Morris County Medical Society**

23 **Bergen Pines County Hospital**
Division of Internal Medicine
Paramus
"Porphyrin Metabolism"

23 **New Jersey Association of School Physicians**
Labor Education Center, Rutgers
New Brunswick
"Economic and Legislative Aspects of School Health Programs"

26 **Kessler Institute of Rehabilitation**
Mayfair Farms
West Orange
20th Anniversary Dinner

30 **New Jersey Association of School Physicians**
Labor Education Center, Rutgers
New Brunswick
"Psychedelic Drugs"

May

6 **Hudson County Medical Society**
Election of Officers

7 **Bergen Pines County Hospital**
Division of Internal Medicine
Paramus
"Present Day Treatment of Chronic Renal Disease"

7 **New Jersey Association of School Physicians**
Labor Education Center, Rutgers
New Brunswick
"Sports Medicine"

8 **Essex County Medical Society**
Annual Meeting

13 **Bergen County Medical Society**

14 **Gloucester County Tuberculosis and Health Association**

14 **Mercer County Medical Society**
State Hospital
Trenton

14 **Ocean County Medical Society**

15 **Gloucester County Medical Society**

15 **Morris County Medical Society**

17-21 **MSNJ Annual Meeting**
Haddon Hall
Atlantic City

18 **The Academy of Medicine of New Jersey**
Symposium: "The Diagnosis of Life and Death"

20 **Warren County Medical Society**

21 **Bergen Pines County Hospital**
Division of Internal Medicine
Paramus
"Adrenalcortical Insufficiency"

22 **Essex and Morris County Medical Societies with Sandoz Pharmaceuticals**
Sandoz Auditorium
Hanover
"Genetic Factors Affecting Drug Response"

26 **Cape May County Medical Society**

27 **Hunterdon County Medical Society**

28 **Middlesex County Medical Society**

June

10 **Bergen County Medical Society**

10 **Cumberland County Medical Society**

11 **Gloucester County Tuberculosis and Health Association**

11 **Middlesex County Medical Society**

11 **Ocean County Medical Society**

12 **Mercer County Medical Society**
Annual Outing
Trenton Country Club
Trenton

17 **Warren County Medical Society**

19 **Gloucester County Medical Society**

19 **Morris County Medical Society**

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BOOK REVIEWS

The Traumatic Neurosis. Lester Keiser, M.D. Philadelphia, 1968, Lippincott. Pp. 244. (Price not stated)

Attitudes toward traumatic neurosis tend to polarize around two extremes. Either traumatic neurosis is seen as a fraud, a pretense of disability by someone greedy for money; or it is pictured as a deep-seated emotional illness precipitated by the accident, and probably embittered by hostility toward the employer, the tort-feasor, or the insurance company. Keiser offers a well balanced view, and here, for the first time in the modern medical and legal literature, is an entire book focused on this distressingly common disability. The author explains the structure of personality in clear terms. He discusses the problem of "secondary gain" which has so often provided an arena for the court room's battle of experts and gives practical suggestions for differentiating the neurotic from the malingerer. In six unique chapters, he comments on the role of the physician, the employer, the family, the attorney, the psychiatrist, and the insurance company. The author offers a compact historical background so that we can see how the concept developed over the past century.

The relatedness of neurosis to certain specialized injuries is well covered. One chapter is a condensed guide-book to the physician in court. A useful glossary and several instructive and illustrative case reports round off the volume. This is a book that was just waiting to be written and it is good that someone had the enterprise to do it. HENRY A. DAVIDSON, M.D.

The Elderly Patient. Bernard A. Stotsky, Ph.D. New York, 1968, Grune and Stratton. Pp. 160. ($5.50)

In this book, the author reviews many of the major problems involving the elderly patient. He touches on many diverse fields of study such as economics, sociology, psychiatry, geriatrics, and philosophy. All of these disciplines form the basis for such topics in the book as economic security, housing, recreation, self-care, family relations, social resources, institutional care, psychiatric problems, physical illness, mental health, and death and bereavement. This plethora of material dealing with the aged population is compressed into a monograph sized book (160 pages). Many of the subjects are treated superficially while others are presented in semi-outline form. The style, however, is clear and literary.

Hospital administrators, social workers, nursing home operators, and families with old parents could benefit from this book. The bibliography of 104 references is an excellent source of additional material for further study. On the other hand, there is very little "medical" material presented that isn't already known by most practicing physicians.

The author pleads the case of the aged patient most eloquently, but even he sounds frustrated by this problem which our nation is facing with its expanding old age population. Let us hope that it is partly solved by the time we join the ever-increasing rocking chair generation. MANUEL J. ROWAN, M.D.

Modern Treatment, Vol. 5, #3: **Treatment of Gallbladder Disease.** Guest Editor, James B. Carey, Jr., M.D., Ph.D. **Treatment of Menopausal Problems.** Guest Editor, Eugene J. Cohen, M.D., New York, 1968, Hoeber Medical Division, Harper and Row. ($16 per year by subscription)

Here is another volume of an interesting set of paperback editions discussing facets of modern treatment. The portion devoted to the gallbladder is particularly helpful as it reviews controversial indications for various forms of treatment. The authors point out certain popular misconceptions, to wit: gall stones do not always get worse (less than half will ever get serious symptoms or require surgery); the risk of cancer of the gallbladder is sufficiently small so that it cannot be used as the only grounds to justify cholecystectomy. There are good arguments advanced, both pro and con, for the surgical treatment of "silent" gall stones.

On the treatment of the menopause *per se,* the relationship between estrogen therapy and cancer, and the treatment of osteoporosis are well presented. Particularly good is the monograph on the psycho-hormonal approach to the menopause.

The book is pithy and concise, and while it presents nothing new, it does discuss the latest trends. It is not a volume for the medical student or intern, but it is a reaffirmation of principles so that a practitioner may know he is following these trends.

SAMUEL E. EINHORN, M.D.

Practical Automation for the Clinical Laboratory. Wilma L. White, B.A., Marilyn M. Erickson, B.S., Sue C. Stevens, B.A., M.A., Ph.D. St. Louis, 1968, The C. V. Mosby Company. Pp. 401. Illustrated ($14.50)

This book is for clinical laboratory directors, residents in clinical pathology, clinical chemists, medical technologists, and teachers and students of medical technology. The book should be in every laboratory library because it is the only currently available source of detailed information on the AutoAnalyzer. More than half of the book is devoted to detailed descriptions of all types of Technicon AutoAnalyzer equipment, including the SMA 12. The descriptions include abundant visual detail and many practical hints for preventive maintenance.

Pathologists will be particularly interested in the description of Technicon's new tissue processor, and in the practical approach taken by the authors.

The introductory chapter on Basic Mechanics and Electronics is good but it should have been entitled Basic Mechanics and *Electricity* because the chapter contains only scant information on electronics. Other chapters of interest describe: the Berkely system for laboratory data handling, the Robot Chemist, the Spectrophor system of electrophoresis, and the fundamentals of atomic absorption spectroscopy.

S. RAYMOND GAMBINO, M.D.

The Future of Human Heredity. Frederick Osborn. New York, 1968, Weybright and Talley. Pp. 133 ($5.95)

This short and readable book presents an introduction to eugenics in modern society. This reviewer found it interesting. The last chapter particularly poses provocative questions regarding the future of the human race. This book should be recommended reading for students and practitioners interested in advancing their knowledge and thinking in this area.

EARL KANTER, M.D.



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Campbell Soup Company, Box 265, Camden, N.J. 08101

No two women are quite alike...





and no other oral contraceptive is quite like Ovulen-21®

Each tablet contains ethynodiol diacetate 1 mg., mestranol 0.1 mg.

The progestin is distinctive, and for some women this may mean a different clinical response. The Compack® tablet dispenser is distinctive; its functional simplicity makes it virtually patient-proof. The acceptance of Ovulen-21 is distinctive... together with Ovulen®, it is more often prescribed than any other individual contraceptive product currently available.

Indication—Oral contraception.

Contraindications—Thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia, undiagnosed abnormal genital bleeding.

Warnings—Watch for the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism, retinal thrombosis); if present or suspected discontinue the drug immediately.

British studies reported in April 1968[1,2] estimate there is a seven- to tenfold increase in mortality and morbidity due to thromboembolic diseases in women taking oral contraceptives. In these controlled retrospective studies, involving 36 reported deaths and 58 hospitalizations due to "idiopathic" thromboembolism, statistical evaluation indicated that the differences observed between users and non-users were highly significant. The conclusions reached in the studies are summarized in the table below:

Comparison of Mortality and Hospitalization Rates Due to Thromboembolic Disease in Users and Non-Users of Oral Contraceptives in Britain.

Category	Mortality Rates		Hospitalization Rates (Morbidity)
	Age 20-34	Age 35-44	Age 20-44
Users of Oral Contraceptives	1.5/100,000	3.9/100,000	47/100,000
Non-Users	0.2/100,000	0.5/100,000	5/100,000

No comparable studies are yet available in the United States. The British data, especially as they indicate the magnitude of the increased risk to the individual patient, cannot be applied directly to women in other countries in which the incidences of spontaneously occurring thromboembolic disease may differ.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or sudden onset of proptosis, diplopia or migraine. Withdraw medication if papilledema or retinal vascular lesions are found.

Since the safety of Ovulen in pregnancy has not been demonstrated, it is recommended that pregnancy be ruled out for any patient who has missed two consecutive periods before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the first missed period.

A small fraction of the hormone agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

Precautions—Pretreatment physical examination should include special reference to the breasts and pelvic organs, and a Papanicolaou smear.

Endocrine and possibly liver function tests may be affected by Ovulen. Therefore, it is recommended that such tests if abnormal be repeated after the drug has been withdrawn for two months.

Pre-existing uterine fibromyomas may increase in size under the influence of progestogen-estrogen preparations.

Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation.

In breakthrough bleeding, and all irregular vaginal bleeding, consider nonfunctional causes. Adequate diagnostic measures are indicated in undiagnosed vaginal bleeding.

Carefully observe patients with a history of psychic depression and discontinue the drug if severe depression recurs.

Any possible influence of prolonged Ovulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study.

A decrease in glucose tolerance has occurred in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be observed carefully while receiving Ovulen.

Because of the effects of estrogens on epiphyseal closure Ovulen should be used judiciously in young patients in whom bone growth is not complete.

The age of the patient constitutes no absolute limiting factor, although Ovulen therapy may mask the onset of the climacteric.

The pathologist should be informed of Ovulen therapy when relevant specimens are submitted.

Adverse Reactions—A statistically significant association has been shown between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: cerebrovascular accidents, neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement, secretion), change in weight, changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, allergic rash, rise in blood pressure in susceptible individuals, mental depression.

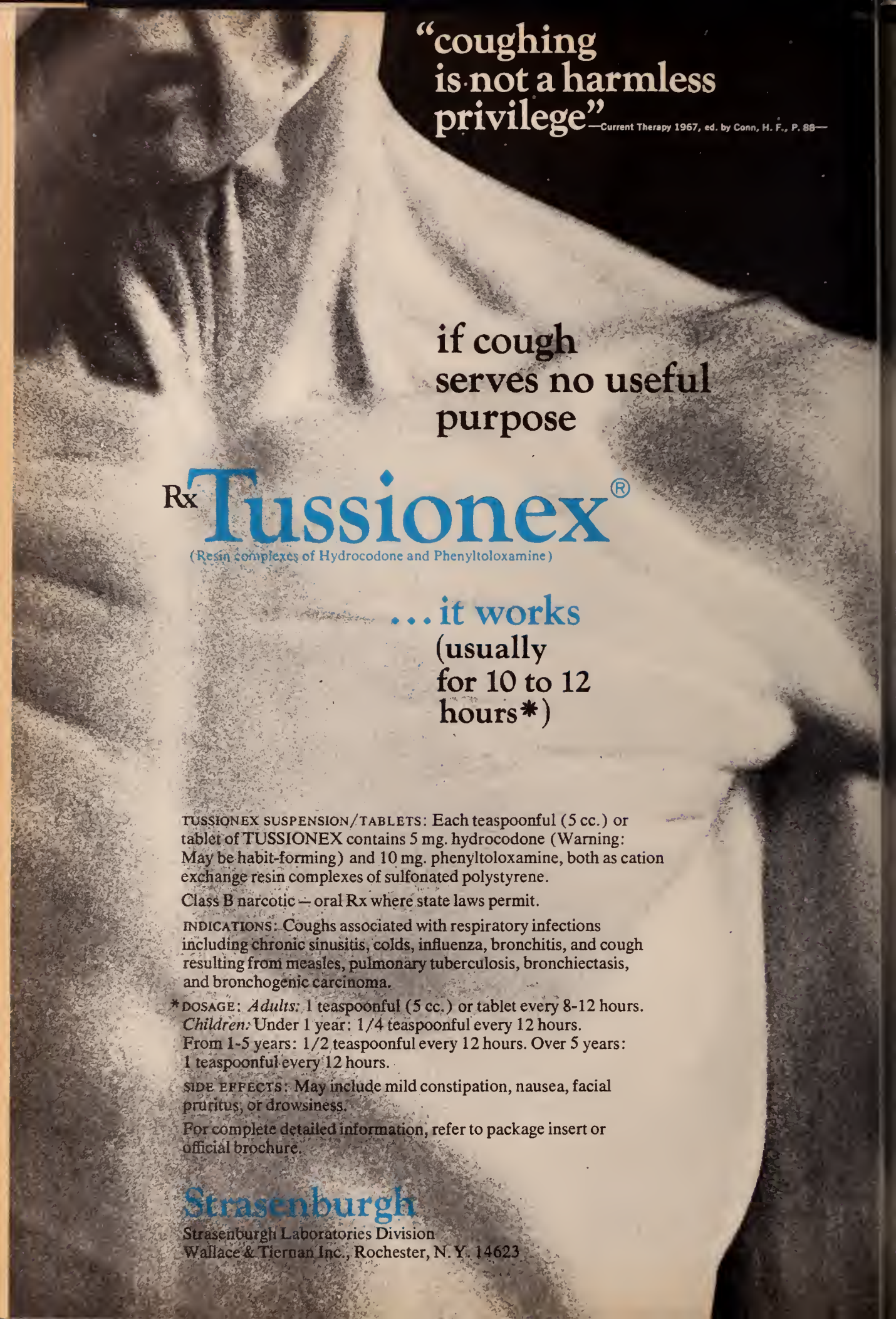
Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme and nodosum, hemorrhagic eruption, itching.

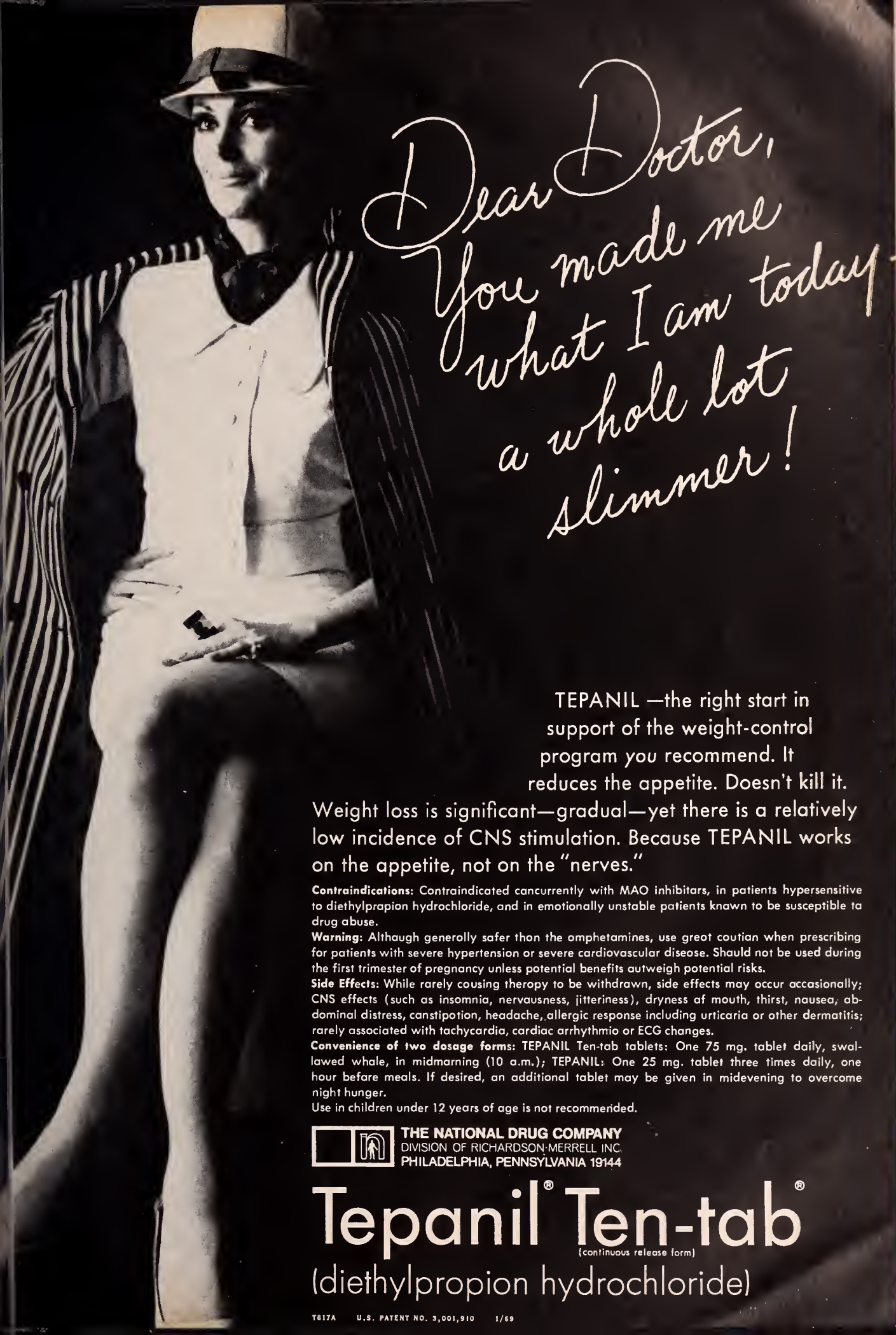
The following laboratory results may be altered by oral contraceptives: hepatic function: increased sulfobromophthalein and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T^3 uptake values; metyrapone test; pregnanediol determination.

References: 1. Inman, W. H. W., and Vessey, M. P.: Brit. Med. J. 2:193-199 (April 27) 1968. 2. Vessey, M. P., and Doll, R.: Brit. Med. J. 2:199-205 (April 27) 1968.

Before prescribing see Detailed Product Information.

SEARLE Where "The Pill" Began
G. D. SEARLE & CO., P. O. Box 5110, Chicago, Illinois 60680


"coughing is not a harmless privilege"—Current Therapy 1967, ed. by Conn, H. F., P. 88—
if cough serves no useful purpose
Rx Tussionex®
(Resin complexes of Hydrocodone and Phenyltoloxamine)
...it works (usually for 10 to 12 hours*)
TUSSIONEX SUSPENSION/TABLETS: Each teaspoonful (5 cc.) or tablet of TUSSIONEX contains 5 mg. hydrocodone (Warning: May be habit-forming) and 10 mg. phenyltoloxamine, both as cation exchange resin complexes of sulfonated polystyrene.
Class B narcotic — oral Rx where state laws permit.
INDICATIONS: Coughs associated with respiratory infections including chronic sinusitis, colds, influenza, bronchitis, and cough resulting from measles, pulmonary tuberculosis, bronchiectasis, and bronchogenic carcinoma.
*DOSAGE: *Adults:* 1 teaspoonful (5 cc.) or tablet every 8-12 hours. *Children:* Under 1 year: 1/4 teaspoonful every 12 hours. From 1-5 years: 1/2 teaspoonful every 12 hours. Over 5 years: 1 teaspoonful every 12 hours.
SIDE EFFECTS: May include mild constipation, nausea, facial pruritus, or drowsiness.
For complete detailed information, refer to package insert or official brochure.
Strasenburgh
Strasenburgh Laboratories Division
Wallace & Tiernan Inc., Rochester, N. Y. 14623



TEPANIL —the right start in support of the weight-control program *you* recommend. It reduces the appetite. Doesn't kill it. Weight loss is significant—gradual—yet there is a relatively low incidence of CNS stimulation. Because TEPANIL works on the appetite, not on the "nerves."

Contraindications: Contraindicated cancurrently with MAO inhibitars, in patients hypersensitive to diethylprapion hydrochloride, and in emotionally unstable patients knawn to be susceptible ta drug abuse.

Warning: Althaugh generolly safer thon the omphetamines, use greot coutian when prescribing for patients with severe hypertension or severe cardiovascular diseose. Shauld not be used during the first trimester of pregnancy unless potential benefits autweigh potential risks.

Side Effects: While rarely cousing theropy to be withdrawn, side effects may occur accasionally; CNS effects (such as insomnia, nervausness, jitteriness), dryness af mouth, thirst, nausea, abdominal distress, canstipotion, headache, allergic response including urticaria or other dermatitis; rarely associated with tachycardia, cardiac arrhythmio or ECG changes.

Convenience of two dosage forms: TEPANIL Ten-tab tablets: One 75 mg. tablet daily, swallowed whale, in midmarning (10 a.m.); TEPANIL: One 25 mg. tablet three times daily, one hour befare meals. If desired, an additional tablet may be given in midevening to overcome night hunger.

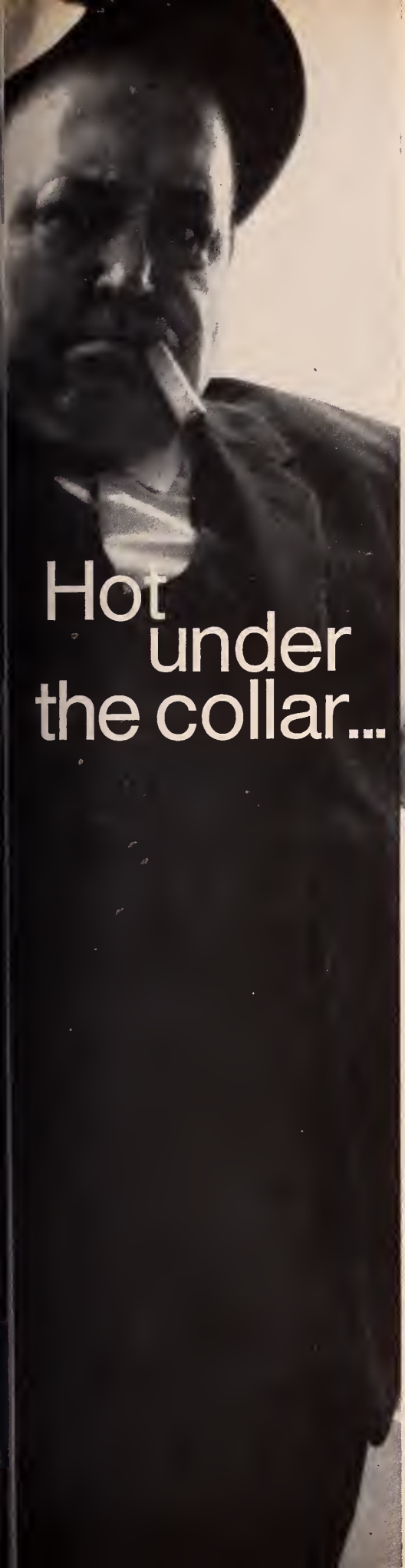
Use in children under 12 years of age is not recommended.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144

Tepanil® Ten-tab®
(continuous release form)

(diethylpropion hydrochloride)

T617A U.S. PATENT NO. 3,001,910 1/69



Hot under the collar...



high under the cuff.

Sometimes
he forgets he has hypertension, gets hot under the collar...high under the cuff.

For such patients, consider **Regroton®**

chlorthalidone	50 mg.
reserpine U.S.P.	0.25 mg.

To lower blood pressure
and allay anxiety in hypertension.

For brief summary of prescribing information, see next page.

RE-6392

Regroton®

Geigy

chlorthalidone 50 mg.
reserpine U.S.P. 0.25 mg.

the once-a-day tablet for anxious hypertensives

Regroton is a combination of two basic antihypertensives designed to lower blood pressure and allay anxiety in hypertension. With Regroton he can keep his shirt on and you can keep his blood pressure down.

Before prescribing, please review carefully the indications, contraindications, warning, precautions, adverse reactions and dosage information below.

Regroton®
Each tablet contains:
chlorthalidone 50 mg.
reserpine U.S.P. 0.25 mg.

Indications: Hypertension.
Contraindications: History of mental depression, hypersensitivity, and most cases of severe renal or hepatic diseases.
Warning: With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small-bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has frequently been required and deaths have occurred. Discontinue coated potassium-containing formulations immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur. Discontinue one week before electroshock therapy, and if depression or peptic ulcer occurs.
Use in pregnancy: Because chlorthalidone may cross the placental barrier and appear in cord blood and thiazides may appear in breast milk, this drug should be used with care in pregnant patients and nursing mothers. When used in women of childbearing age, the potential benefits of the drug should be weighed against the possible hazards to the fetus. Use of chlorthalidone may result in fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult. Increased respiratory secretions, nasal congestion, cyanosis and anorexia may occur in infants born to reserpine-treated mothers.
Precautions: Antihypertensive therapy with this drug should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents, other potent antihypertensive drugs, or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. To avoid hypotension during surgery, discontinue therapy with this agent two weeks prior to elective surgical procedures. In emergency surgery, use, if needed, anticholinergic or adrenergic drugs or other supportive measures as indicated. Because of the possibility of progression of renal damage, periodic kidney function tests are indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated. Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, the drug should be discontinued and potassium supplements given, provided the patient does not have marked oliguria.
Take particular care in cirrhosis or severe ischemic heart disease and in patients receiving corticosteroids, ACTH, or digitalis. Severe salt restriction is not recommended. Use cautiously in patients with ulcerative colitis or gallstones (biliary colic may be precipitated). Bronchial asthma may occur in susceptible patients.
Adverse Reactions: The drug is generally well tolerated. The most frequent side effects are nausea, gastric irritation, vomiting, diarrhea, constipation, muscle cramps, headache, dizziness and acute gout. Other potential side effects include angina pectoris, anxiety, depression, bradycardia and ectopic cardiac rhythms (especially when used with digitalis), drowsiness, dull sensorium, hyperglycemia and glycosuria, hyperuricemia, lassitude, restlessness, transient myopia, impotence or dysuria, orthostatic hypotension which may be potentiated when chlorthalidone is combined with alcohol, barbiturates or narcotics, leukopenia, aplastic anemia, skin rashes, thrombocytopenia, agranulocytosis, nasal stuffiness, increased gastric secretions, nightmare, purpura, urticaria, ecchymosis, weakness, uveitis, optic atrophy and glaucoma, and pruritus. Eruptions and/or flushing of the skin, a reversible paralysis agitans-like syndrome, blurred vision, conjunctival injection, increased susceptibility to colds, dyspnea, weight gain, decreased libido, dryness of the mouth, deafness, anorexia, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Jaundice, xanthopsia, paresthesia, photosensitization and necrotizing angiitis are possible.
Average Dosage: One tablet daily with breakfast.
Availability: Pink, single-scored tablets in bottles of 100 and 1000.
(B)46-600-C
For details, please see complete prescribing information.

Geigy Pharmaceuticals
Division of
Geigy Chemical Corporation
Ardsley, New York 10502

See next page for prescribing informatio



You've made it one of your specifics in acute otitis media

DECLOMYCIN
DEMETHYLCHLORTETRACYCLINE



You've made it one of your specifics in acute otitis media

DECLOMYCIN acts against many strains of H. influenzae, pneumococci and streptococci, the most common invaders. In otitis media, where it is difficult to isolate the causative organism, this coverage may be important. However, some strains may be resistant and other pathogens can be involved.

You've found the high serum levels of DECLOMYCIN important, too. Its prolonged action permits convenient 300 mg b.i.d. or 150 mg q.i.d. administration.

When specimens are obtainable, your culture studies will indicate the usefulness of DECLOMYCIN.

Effectiveness: DECLOMYCIN Demethylchlortetracycline should be equally or more effective therapeutically than other tetracyclines in infections caused by organisms sensitive to the tetracyclines.

Contraindication: History of hypersensitivity to demethylchlortetracycline.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a case of exfoliative dermatitis has been reported. Photosensitivity, onycholysis and discoloration of the nails (rare). Kidney—rise in BUN apparently dose-related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

DECLOMYCIN®
DEMETHYLCHLORTETRACYCLINE

Capsules: 150 mg; **Tablets:** film coated, 300 mg, 150 mg and 75 mg of demethylchlortetracycline HCl.

LEDERLE LABORATORIES, A Division of
American Cyanamid Company, Pearl River, New York

Lederle

now she can cope...

hanks to

Butisol SODIUM®

SODIUM BUTABARBITAL)

he "daytime sedative" for veryday situational stress

hen stress is situational—environmental pressure, orry over illness—the treatment often calls for an xiety-allaying agent which has a prompt and edictable calming action and is remarkably well lerated. Butisol Sodium (sodium butabarbital) eets this therapeutic need.

fter 30 years of clinical use . . . still a first choice nong many physicians for dependability, safety and onomy in mild to moderate anxiety.

ontraindications: Porphyria or sensitivity to arbiturates.

ecautions: Exercise caution in moderate to severe epatic disease. Elderly or debilitated patients may act with marked excitement or depression.

dverse Reactions: Drowsiness at daytime sedative se levels, skin rashes, "hangover" and systemic sturbances are seldom seen.

arning: May be habit forming.

sual Adult Dosage: As a daytime sedative, mg. (¼ gr.) to 30 mg. (½ gr.) t.i.d. or q.i.d.

vailable for daytime sedation: Tablets, 15 mg. (¼ gr.), mg. (½ gr.); Elixir, 30 mg. per 5 cc. (alcohol 7%).

UTICAPS® [Capsules Butisol Sodium (sodium butabarbital)] mg. (¼ gr.), 30 mg. (½ gr.).

McNEIL

cNeil Laboratories, Inc., Fort Washington, Pa.





If you think the pink pill for U.R.I. symptoms is built for speed and endurance you're on the right track.

Here is a tablet that begins to relieve symptoms of upper respiratory infection quickly—a tablet that works for hours to make it easy for your patient to enjoy continuous relief.

Novahistine Singlet combines effective dosage of an antipyretic-analgesic with a vasoconstrictor-antihistamine formulation to relieve not only the congestion, but also the fever and the aches and pains that almost always accompany upper respiratory infections.

A total daily dosage of 3 or 4 tablets will normally provide the continuous relief your patient expects. Use with caution in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result.

PITMAN-MOORE Division of The Dow Chemical Company, Indianapolis, Indiana.

Novahistine®
Singlet decongestant-analgesic

(Each tablet contains: phenylephrine hydrochloride, 40 mg.; chlorpheniramine maleate, 8 mg.; acetaminophen, 500 mg.)

DOW



The Fortunate One.

Her urinary tract infection reveals itself through pain and discomfort.

While the pain and discomfort of a G.U. infection are anything but pleasant, the patient may be luckier than she realizes. That burning sensation (and/or frequency, urgency, dysuria) is a usually reliable sign of a urinary tract infection. And it's her good fortune that her infection won't go undetected...or untreated.

Azo Gantanol® therapy usually provides analgesic action within one-half hour, while control of the infection begins within two hours. Azo, a specific urinary analgesic, soothes inflamed mucosa to give symptomatic relief. At the same time, the antibacterial component, Gantanol (sulfamethoxazole), achieves therapeutic levels in the blood and urine, with diffusion into interstitial fluids. Azo Gantanol—a good choice when urinary tract infection reveals itself through symptomatic distress.

Before prescribing, please consult complete product information, a summary of which appears on opposite page.

Azo Gantanol®

(Each tablet contains 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl.)

Azo for the pain
Gantanol®
(sulfamethoxazole)
for the pathogens

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Urinary tract infections with associated pain or discomfort when due to susceptible organisms; prophylactically in urologic surgery, catheterization and instrumentation.

Contraindicated in sulfonamide-sensitive patients, pregnant females at term, premature infants, newborn infants during the first three months of life, glomerular nephritis, severe hepatitis, uremia and pyelonephritis of pregnancy with gastrointestinal disturbances.

Warnings: Use only after critical appraisal in patients with liver damage, renal damage, urinary obstruction or blood dyscrasias. If toxic or hypersensitivity reactions or blood dyscrasias occur, discontinue therapy. In closely intermittent or prolonged therapy, blood counts and liver and kidney function tests should be performed.

Precautions: Observe usual sulfonamide therapy precautions including maintenance of an adequate fluid intake. Use with caution in patients with histories of allergies and/or asthma. Patients with impaired renal function should be followed closely since renal impairment may cause excessive drug accumulation. Occasional failures may occur due to resistant microorganisms. Not effective in virus and rickettsial infections.

Adverse Reactions: Headache, nausea, vomiting, urticaria, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, skin rash, Stevens-Johnson syndrome, injection of the conjunctiva and sclera, petechiae, purpura, hematuria or crystalluria may occur, in which case the dosage should be decreased or the drug withdrawn.

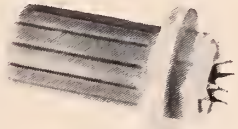
Dosage: Adults—4 tablets initially, then 2 tablets morning and evening.

How Supplied: Tablets, bottles of 50.

ROCHE
Roche
LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

TB is still around.

In 1967 almost 45,000 new active cases were reported. Isn't that a good reason to make tuberculin testing with the white LEDERTINE™ Applicator a routine part of your physical examinations?



TUBERCULIN TINE TEST
(Rosenthal) with Old Tuberculin

Precautions: With a positive reaction, consider further diagnostic procedures. Use with caution in persons with active tuberculosis or known allergy to acacia. Vesiculation, ulceration, or necrosis may occur at the test site in highly sensitive persons.

Lederle LEDERLE LABORATORIES
A Division of American Cyanamid Company, Pearl River, N.Y.
472-9

HIGHLAND HOSPITAL

ASHEVILLE, NORTH CAROLINA

Founded 1904

A DIVISION OF THE DEPARTMENT OF PSYCHIATRY OF DUKE UNIVERSITY

Accredited by the Joint Commission on Accreditation and Certified for Medicare

Complete facilities for evaluation and intensive treatment of psychiatric patients, including individual psychotherapy, group therapy, psychodrama, electro-convulsive therapy, Indoklon convulsive therapy, drugs, social service work with families, family therapy, and an extensive and well organized activities program, including occupational therapy, art therapy, athletic activities and games, recreational activities and outings. The treatment program of each patient is carefully supervised in order that the therapeutic needs of each patient may be realized.

High school facilities for a limited number of appropriate patients are now available on grounds. The School Program is fully integrated into the hospital treatment program and is accredited through the Asheville School System.

Complete modern facilities with 85 acres of landscaped and wooded grounds in the City of Asheville.

Brochures and information on financial arrangements available

Contact: Mrs. Elizabeth Harkins, ACSW, Coordinator of Admissions

or

Charles W. Neville, Jr., M.D.

Assistant Professor of Psychiatry and Medical Director

Area Code 704-253-2761



For the "Cheater Eater"

Formulas: Each 'Dexamyl' *Spansule* capsule No. 1 contains 10 mg. of Dexedrine® (brand of dextroamphetamine sulfate) and 1 gr. of amobarbital, derivative of barbituric acid (Warning, may be habit forming). Each 'Dexamyl' *Spansule* capsule No. 2 contains 15 mg. of Dexedrine (brand of dextroamphetamine sulfate) and 1½ gr. of amobarbital (Warning, may be habit forming).
Before prescribing, see complete prescribing information in SK&F literature or *PDR*.
Contraindications: Hyperexcitability, undue restlessness, hyperthyroidism, porphyria; in patients on MAO inhibitors.
Precautions: Use with caution in patients hypersensitive to sympathomimetics or barbiturates and in coronary or cardiovascular disease or severe hypertension. Excessive use of the amphetamines by unstable individuals may result in a psychological dependence. Rarely, symptoms of toxic psychosis (hallucinations, confusion, panic states, etc.) may occur with amphetamines, usually after prolonged high dosage. In these instances, withdraw the medication. Use cautiously in pregnant patients, especially in the first trimester.
Adverse Reactions: Overstimulation, restlessness, insomnia, g.i. disturbances, diarrhea, palpitation, tachycardia, elevated blood pressure, tremor, sweating, impotence and headache.
Supplied: In bottles of 50.

Dexamyl®

brand of dextroamphetamine sulfate and amobarbital

Spansule®

brand of sustained release capsules

curbs appetite
encourages normal activity
dispels diet discouragement

SK&F
Smith Kline & French Laboratories

So he'll breathe easier:

relieve anxiety while you relieve pain.

Relief of pain is usually a major goal in traumatic conditions. But often of importance, too, is alleviation of anxiety and tension that may heighten patient discomfort.

Single-prescription, non-narcotic Equagesic may effectively relieve pain. *And* ease anxiety and tension.

TABLETS

Equagesic®

(meprobamate and ethoheptazine citrate with aspirin) Wyeth®

IN BRIEF.

Contraindications: History of sensitivity or severe intolerance to aspirin, meprobamate or ethoheptazine citrate.

Warnings: USE IN PREGNANCY: Safety for use during pregnancy or lactation has not been established; therefore, it should be used in pregnant patients or women of child-bearing age only when the physician judges its use essential to the patient's welfare.

Precautions: Keep out of reach of children. Not recommended for patients 12 years old or less. Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use of meprobamate in susceptible persons—as alcoholics, ex-addicts, severe psychoneurotics—has resulted in dependence or habituation. Withdraw gradually after prolonged excessive dosage to avoid possibly severe withdrawal reactions including epileptiform seizures. Warn patients of possible reduced alcohol tolerance, with resultant slowed reactions and impaired judgment and coordination. If drowsiness, ataxia or visual disturbances (impairment of accommodation and visual acuity) occur, reduce dose. If symptoms persist, patients should not operate machinery or drive. After meprobamate overdose, prompt sleep, reduction of blood pressure, pulse and respiratory rates to basal levels, and hyperventilation are reported. Give cautiously and in small amounts to patients with suicidal tendencies. Treat attempted suicide (has resulted in coma, shock, vasomotor and respiratory collapse and anuria) with gastric lavage and appropriate symptomatic therapy (CNS stimulants and pressor amines as indicated). Two instances of accidental or intentional significant overdosage with ethoheptazine and aspirin have been reported. These were accompanied by CNS depression (drowsiness and lightheadedness) but resulted in uneventful recovery. On basis of pharmacologic data, CNS stimulation could be anticipated, with nausea, vomiting and salicylate intoxication (requires induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, and observation for hypoprothrombinemic hemorrhage [usually requires whole blood transfusions]).

Adverse Reactions: Ethoheptazine and aspirin may cause nausea with or without vomiting and epigastric distress, in a small percentage of patients. Dizziness is rare at recommended dosage. Meprobamate may cause drowsiness, ataxia and rarely allergic or idiosyncratic reactions. These reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses. Such patients may have had no previous contact with meprobamate and may or may not have an allergic history. Mild reactions are characterized by urticarial or erythematous maculopapular rash. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. If allergic reaction occurs, discontinue meprobamate; do not reinstitute. Severe reactions, observed very rarely, include fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. These cases should be treated symptomatically including, when indicated, such medication as epinephrine, antihistamine and possibly hydrocortisone. A few cases of leukopenia, usually transient, have been reported on continuous use. Rarely, aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia have been reported, almost always in presence of known toxic agents.

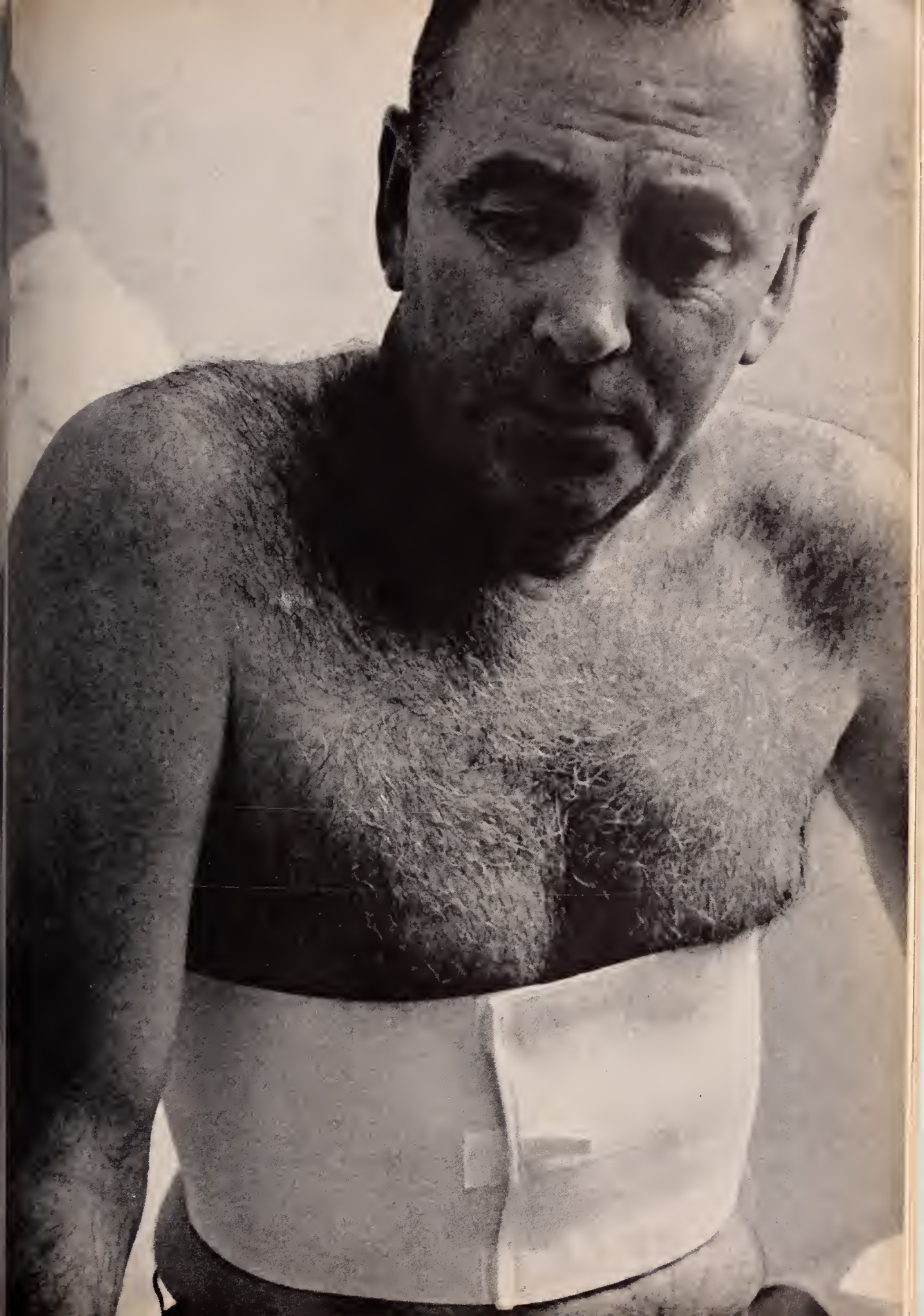
Overdosage: See precautions section for management of overdosage.

Composition: 150 mg. meprobamate, 75 mg. ethoheptazine citrate and 250 mg. aspirin per tablet.

Wyeth Laboratories Philadelphia, Pa.

Photo professionally posed.





in the treatment of

IMPOTENCE



Android®

(thyroid-androgen) TABLETS

Effectiveness confirmed by another double blind study*

1.SUMMARY

ANDROID	GOOD TO EXCELLENT 75%
PLACEBO	20%

2. Forty cases reported.
3. Cites synergism between androgen and thyroid.
4. No side effects in patients treated.
5. Alleviation of fatigue noted
6. Case histories on 4 patients.
7. Although psychotherapy still needed, role of chemotherapy cannot be disputed.

**"Sexual impotence treatment with methyl testosterone – thyroid (ANDROID) a double blind study" – Mantesona, Evangelista: Clinical Medicine, April 1966.*

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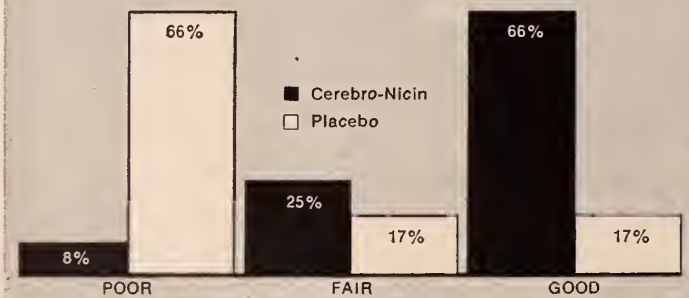
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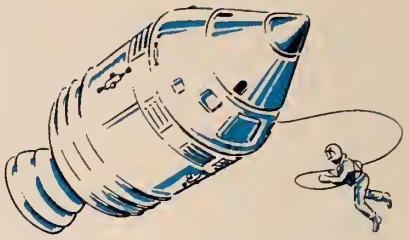
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Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxic or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

BALCONY

the JOURNAL
OF THE MEDICAL SOCIETY OF NEW JERSEY

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ACCIDENT AND HEALTH INSURANCE

$1,200 a month maximum BASIC total disability benefit.

Accident: from 1st day, up to 5 years (Partial Accident Disability, half benefit up to six months)

PLUS Sickness: from 8th day, up to 2 years

Accident: may be EXTENDED to Lifetime
Sickness: may be EXTENDED to 7 years

$1,000 a month maximum NEW LONG-TERM PLAN.
Payable up to Lifetime for accident — Age 65 for sickness
Choice of waiting periods:
Benefits may begin on 1st, 15th, 31st, 61st or 91st day.

★ ★ ★

LIFE INSURANCE

$10,000 to $100,000 of Convertible Term Life Insurance.
(Guaranteed exchangeable at any time into Permanent Cash Value life insurance without medical examination)

★ ★ ★

MAJOR EXPENSE INSURANCE

$15,000 maximum for Covered Expenses as stated in the policy for each accident or sickness, covering member, spouse, and eligible children. $500 deductible, 20% co-insurance. (Physicians' and surgeons' fees are not a Covered Expense.)

★ ★ ★

SIX POINT, HIGH-LIMIT ACCIDENT INSURANCE

$200,000 maximum for member, covering accidental death, dismemberment, loss of sight, total and permanent disability, exposure and disappearance.

$100,000 maximum for spouse (without disability benefit).

APPLICATIONS CONSIDERED AT ANY TIME

Applications are subject to age limits and other company rules and regulations for acceptance of risks. New members have special privileges during the first few months of membership; ask for specific details if you were recently elected or have applied for membership.

Information and claim service are as close as your telephone.

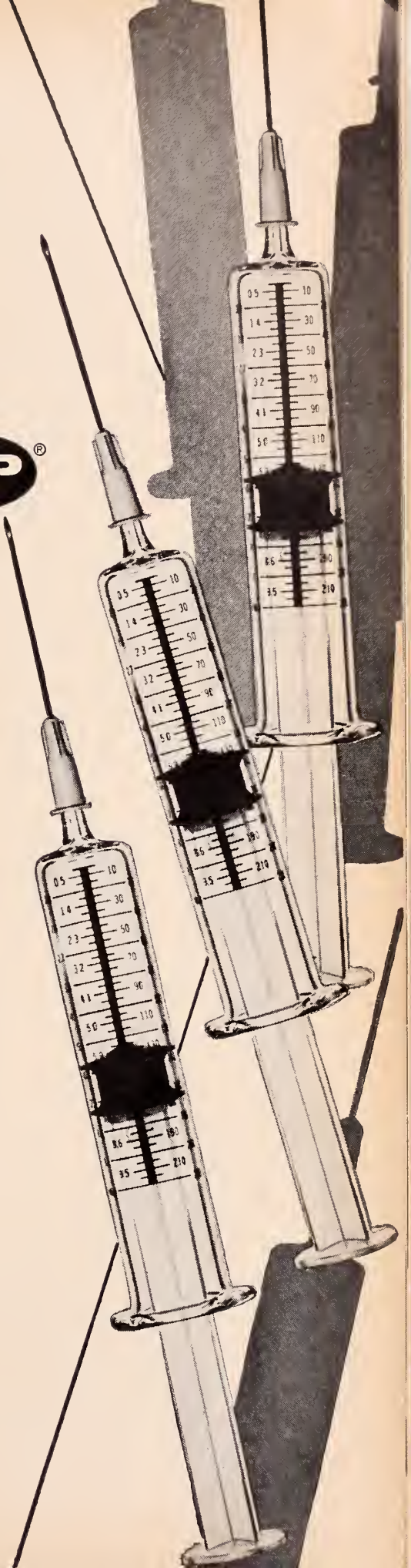
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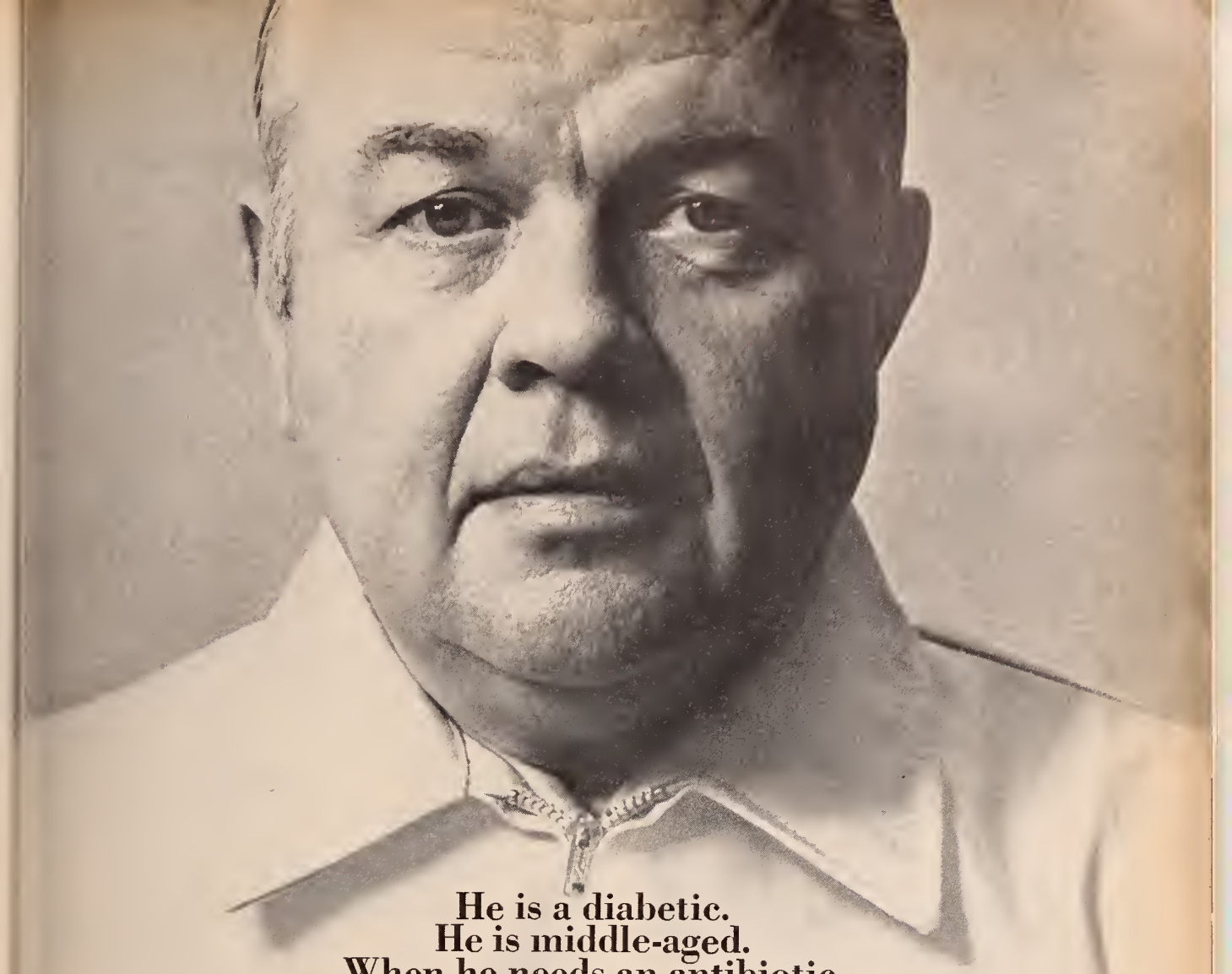
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He is a diabetic.
He is middle-aged.
When he needs an antibiotic
he may be a candidate for

DECLOSTATIN® 300

Demethylchlortetracycline HCl 300 mg and Nystatin 500,000 units
CAPSULE-SHAPED TABLETS Lederle

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To guard susceptible patients against intestinal monilial overgrowth during broad-spectrum therapy—the protection of nystatin is combined with demethylchlortetracycline in DECLOSTATIN.

For your susceptible candidates, prescribe DECLOSTATIN—the broad-spectrum therapy that prevents monilial overgrowth.

Effectiveness: Because its antibacterial component is DECLOMYCIN Demethylchlortetracycline, DECLOSTATIN should be equally or more effective therapeutically than other tetracyclines in infections caused by tetracycline-sensitive organisms. The antifungal component, Nystatin, protects against superinfection by antibiotic-resistant fungal overgrowth (particularly monilia) in the intestinal tract.

Contraindication: History of hypersensitivity to demethylchlortetracycline or nystatin.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

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The AMBAR SCRAPBOOK of Obesity Oddities
FACT & LEGEND



CONTROL FOOD AND MOOD ALL DAY LONG WITH A SINGLE MORNING DOSE

AMBAR #2 EXTENTABS®

methamphetamine HCl 15 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

One Ambar Extentab before breakfast can help control most patients' appetite for up to 12 hours. Methamphetamine, the appetite suppressant, gently elevates mood and helps overcome dieting frustrations. Phenobarbital, the sedative in Ambar, controls irritability and anxiety...helps maintain a state of mental calm and equanimity. Both work together to ease the tensions that erode the willpower during periods of dieting.

Also available: Ambar #1 Extentabs®—methamphetamine hydrochloride 10 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

BRIEF SUMMARY/**Indications:** Ambar suppresses appetite and helps offset emotional reactions to dieting. **Contraindications:** Hypersensitivity to barbiturates or sympathomimetics; patients with advanced renal or hepatic disease. **Precautions:** Administer with caution in the presence of cardiovascular disease or hypertension. **Side Effects:** Nervousness or excitement occasionally noted, but usually infrequent at recommended dosages. Slight drowsiness has been reported rarely. See package insert for further details.

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Some New Considerations for Participating in Blue Shield's Basic Program

As a former practicing physician and a Blue Shield Participating Physician for over twenty-five years, I can assure you that I am well aware that physicians fail to become Participaing Physicians and cease to participate for two reasons: One, the Blue Shield fees paid under the Basic Contract are sometimes below the usual and customary fees, and two, many patients believe that they are entitled to service benefits when they are not, because they are over the income limit. Nevertheless I think it is to a physician's interest to continue to participate for the following reasons:

1. The three million people in New Jersey covered by Blue Shield are our best defense for the private practice of medicine. Every physician has a responsibility to the public to make private medical care work, because it has many advantages for the patient over any other type of medical care. It is also true that the physician, in protecting the public, is protecting himself.

2. Only about 40% of the families who now have Blue Shield coverage have annual incomes of less than $7500, hence a substantial portion of your Blue Shield patients are not entitled to service benefits, and you may charge them your usual fee.

3. It is the responsibility of the patient to prove to the physician that he is entitled to service benefits by producing a copy of the subscriber's income tax return for the previous year, when requested. Some physicians have approached this problem by using a bill for eligible services rendered to Blue Shield patients similar to that shown on this page; it can state "Paid by N.J. Blue Shield" or "Will be paid by N.J. Blue Shield." These physicians report that their collection of balances is excellent, and any argument with patients concerning income is eliminated.

4. In the near future we intend to eliminate any reference to income on the Blue Shield claim form, and substitute for it a statement that if the patient claims service benefits he must prove his entitlement by showing the Participating Physician his latest income tax report, when requested.

5. Of course, when you are satisfied that a patient is entitled to Service Benefits, you will have to accept the Blue Shield payment as payment in full. However, the purchasing power of a family income (husband and wife) of $7500 has shrunk to less than $5500 in the past nine years, due to inflation. I think you will agree that this borders on medical indigency, and deserves some financial consideration from the attending physician. In such cases the Blue Shield payment seems fair.

6. On the other hand, when the income is over the Service Benefits limit, you have no obligation to accept the Blue Shield fee as full payment; for those patients Blue Shield payment is simply an indemnity payment toward your usual fees, and you may charge the patient the balance of the customary fee.

7. There is one great tangible benefit from being a Participting Physician: The checks for all your services to all Blue Shield patients will be mailed directly to you and not to your patients. Some patients who receive insurance checks postpone paying the doctor and utilize the funds for other purposes. This certainly can be a source of aggravation of both sides, which is eliminated in cases where the Blue Shield check goes directly to you.

You can help to protect the private practice of medicine for New Jersey patients and physicians and preserve the doctor-patient relationship by assuring adequate prepayment voluntary insurance for the people of New Jersey through becoming a Participating Physician with the Blue Shield Plan. If you are in the minority of physicians who do not participate, please give the foregoing your thoughtful consideration; we hope you will join with the more than 75% of the profession who do participate by mailing the application below.

Joseph P. Donnelly M.D.
President

JOHN DOE, M.D.
MAIN STREET, NEWARK, N.J.

Mr. John Smith
First Street
Newark, New Jersey

For professional services rendered to Mrs. Smith	$ 225.00
Paid by New Jersey Blue Shield	175.00
Balance Due	50.00

If your income level entitles you to Blue Shield "service benefits", we will gladly excuse the balance shown on this bill if you present proof that your income, as listed in your last year's income tax report, was below the limit for "service benefits" under your Contract.

Dr. Joseph P. Donnelly, President
Medical-Surgical Plan of New Jersey
500 Broad Street
Newark, New Jersey 07101

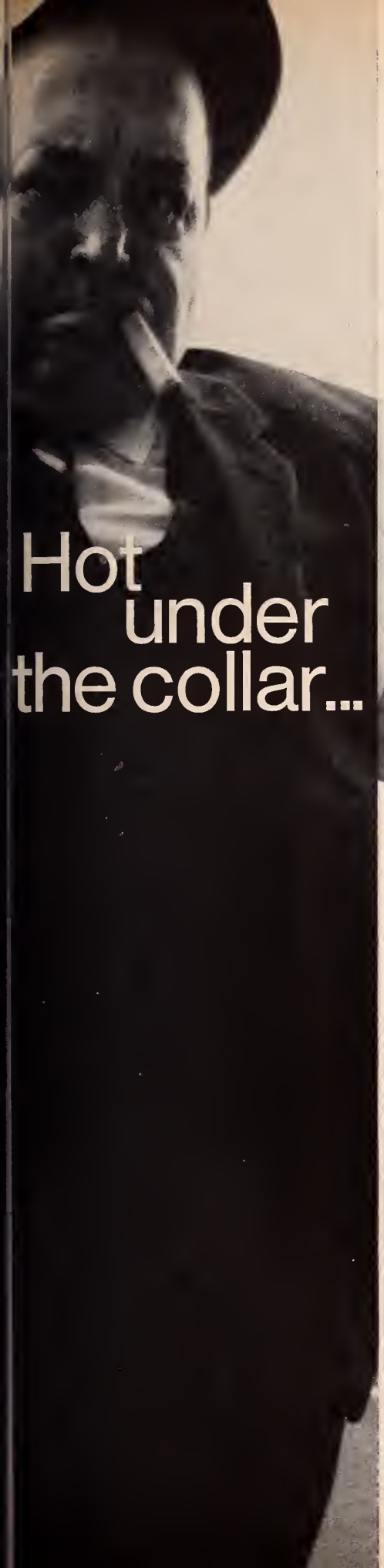
Please send me a Blue Shield Participation Agreement

Name_____

Address_____

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(New Jersey Blue Shield Plan)
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Hot under the collar...

high under the cuff.



Sometimes
he forgets he has hypertension, gets hot under the collar...high under the cuff.

For such patients, consider **Regroton®**

chlorthalidone	50 mg.
reserpine U.S.P.	0.25 mg.

To lower blood pressure
and allay anxiety in hypertension.

For brief summary of prescribing information, see next page.

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chlorthalidone 50 mg.
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the once-a-day tablet for anxious hypertensives

Regroton is a combination of two basic antihypertensives designed to lower blood pressure and allay anxiety in hypertension. With Regroton he can keep his shirt on and you can keep his blood pressure down.

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Each tablet contains:
chlorthalidone 50 mg.
reserpine U.S.P. 0.25 mg.

Indications: Hypertension.
Contraindications: History of mental depression, hypersensitivity, and most cases of severe renal or hepatic diseases.
Warning: With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small-bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has frequently been required and deaths have occurred. Discontinue coated potassium-containing formulations immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur. Discontinue one week before electroshock therapy, and if depression or peptic ulcer occurs.
Use in pregnancy: Because chlorthalidone may cross the placental barrier and appear in cord blood and thiazides may appear in breast milk, this drug should be used with care in pregnant patients and nursing mothers. When used in women of childbearing age, the potential benefits of the drug should be weighed against the possible hazards to the fetus. Use of chlorthalidone may result in fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult. Increased respiratory secretions, nasal congestion, cyanosis and anorexia may occur in infants born to reserpine-treated mothers.
Precautions: Antihypertensive therapy with this drug should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents, other potent antihypertensive drugs, or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. To avoid hypotension during surgery, discontinue therapy with this agent two weeks prior to elective surgical procedures. In emergency surgery, use, if needed, anticholinergic or adrenergic drugs or other supportive measures as indicated. Because of the possibility of progression of renal damage, periodic kidney function tests are indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated. Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, the drug should be discontinued and potassium supplements given, provided the patient does not have marked oliguria.
Take particular care in cirrhosis or severe ischemic heart disease and in patients receiving corticosteroids, ACTH, or digitalis. Severe salt restriction is not recommended. Use cautiously in patients with ulcerative colitis or gallstones (biliary colic may be precipitated). Bronchial asthma may occur in susceptible patients.
Adverse Reactions: The drug is generally well tolerated. The most frequent side effects are nausea, gastric irritation, vomiting, diarrhea, constipation, muscle cramps, headache, dizziness and acute gout. Other potential side effects include angina pectoris, anxiety, depression, bradycardia and ectopic cardiac rhythms (especially when used with digitalis), drowsiness, dull sensorium, hyperglycemia and glycosuria, hyperuricemia, lassitude, restlessness, transient myopia, impotence or dysuria, orthostatic hypotension which may be potentiated when chlorthalidone is combined with alcohol, barbiturates or narcotics, leukopenia, aplastic anemia, skin rashes, thrombocytopenia, agranulocytosis, nasal stuffiness, increased gastric secretions, nightmare, purpura, urticaria, ecchymosis, weakness, uveitis, optic atrophy and glaucoma, and pruritus. Eruptions and/or flushing of the skin, a reversible paralysis agitans-like syndrome, blurred vision, conjunctival injection, increased susceptibility to colds, dyspnea, weight gain, decreased libido, dryness of the mouth, deafness, anorexia, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Jaundice, xanthopsia, paresthesia, photosensitization and necrotizing angiitis are possible.
Average Dosage: One tablet daily with breakfast.
Availability: Pink, single-scored tablets in bottles of 100 and 1000.
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For details, please see complete prescribing information.

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This unique professional credit card exclusively for health services helps you get out of the credit and collection business . . . frees your capital for investment. You merely mail your draft to Medi Card on simple, easy-to-use forms supplied at no cost. Medi Card pays you promptly, less only a 6% service fee. There is no commitment on your part, nothing to join, no directory or listing of any kind. *Your patients benefit, in other ways, too!* Medi Card makes from $100 to $5000 available to patient-members exclusively for professional health services . . . lets them take up to 24 months to pay. As an additional benefit, Medi Card offers a round-the-clock computerized emergency medical information service for cardholders.

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AND OTHER BONA FIDE HEALTH SERVICE CHARGES

MEDI CARD, INC.
P.O. Box 650
Bala Cynwyd, Pa. 19004



Medi Card answers some frequently asked questions.

Q. Does Medi Card conflict with pre-paid health plans?

A. No. On the contrary, Medi Card both complements and supplements Blue Cross/Blue Shield and other pre-paid insurance programs; that portion which your patient would normally pay by cash may be charged to Medi Card.

Q. Can Medi Card now take over my patients' accounts receivable?

A. Medi Card cannot take over your patients' accounts receivable at this time but will process all patient applications received from you without charge.

Q. Do you make an individual credit check on each one of my patients?

A. Every application for Medi Card receives a thorough credit check before any card is issued.

Q. Are patient application forms readily available?

A. Yes. Applications to Medi Card are included in your professional kit and additional ones are available without charge.

Q. What methods will you use for collecting delinquent accounts? How does my state professional society feel about this?

A. Delinquent accounts will be automatically transferred to the same collection agency currently used by your local professional society.

Q. How does the AMA, the ADA, the AHA and my state professional society feel about Medi Card?

A. All terms of the Medi Card program have been presented and thoroughly discussed with these professional associations. They have informed us that they neither approve nor disapprove of Medi Card, they have no objections to our presenting the program to the individual members of the professions.

Q. Do I have to join, or become a member of Medi Card? Is there anything to pay in order to participate in the Medi Card program?

A. There is nothing to pay. You neither join Medi Card nor make any agreement with Medi Card. You merely honor the credit card upon its presentation, and are required to sign a statement accompanying the patient's first draft acknowledging your understanding of the program and Medi Card's 6% service charge.

Q. Can a card holder's Medi Card be used by various members of the family?

A. Medi Card may be used by any member of the family providing the card holder signs the Medi Card draft.

Q. What about Medi Card's financial responsibility?

A. Medi Card, a publicly held corporation, is associated in this program with Financial Services, Inc., a wholly owned subsidiary of the Diners Club.

Q. How much paperwork is involved?

A. The Medi Card draft is the simplest form ever devised for the payment of professional fees and services. Only two lines of the draft have been allotted for briefly outlining treatment. It is as fast as writing a personal check.

Q. Is there recourse to me in the event the patient does not pay Medi Card?

A. There is no recourse whatsoever. All the collection responsibility lies with Medi Card thus freeing you to maintain a professional relationship with your patient.

Q. Under what conditions will Medi Card refuse to pay a draft?

A. (1) Where the charge is incurred after the expiration date shown on the card. (2) Failure to fill out and mail processing card to us before, or along with, first draft.

Q. How much of my bill will Medi Card pay?

A. Medi Card will pay you up to the amount of credit shown on the face of the card, less the service charge.

Q. How does Medi Card protect the cardholder?

A. (1) Medi Card protects the cardholder by providing funds for professional services in amounts from $100 to $5,000 when they are needed. (2) Medi Card further protects the cardholder and his family by providing a 24-hour nationwide emergency medical information service making personal medical information available immediately through the use of a Medi Card toll-free telephone credit call. (3) In addition, this service provides all necessary professional payment information to the caller.

Q. How will I know each individual patient's Credit Limit?

A. Each patient's Credit Limit is clearly shown on the face of his Medi Card.

Q. Will you publish a list of professional participants?

A. No. Medi Card will not publish such a list because professional participants are not members of Medi Card.

'hat must I do to join Medi Card?

ou do not join Medi Card so there is nothing to do - no membership forms or questionnaires to fill ut. Medi Card provides you with a professional kit at comes without cost. Reorders of Medi Card afts are also available free.

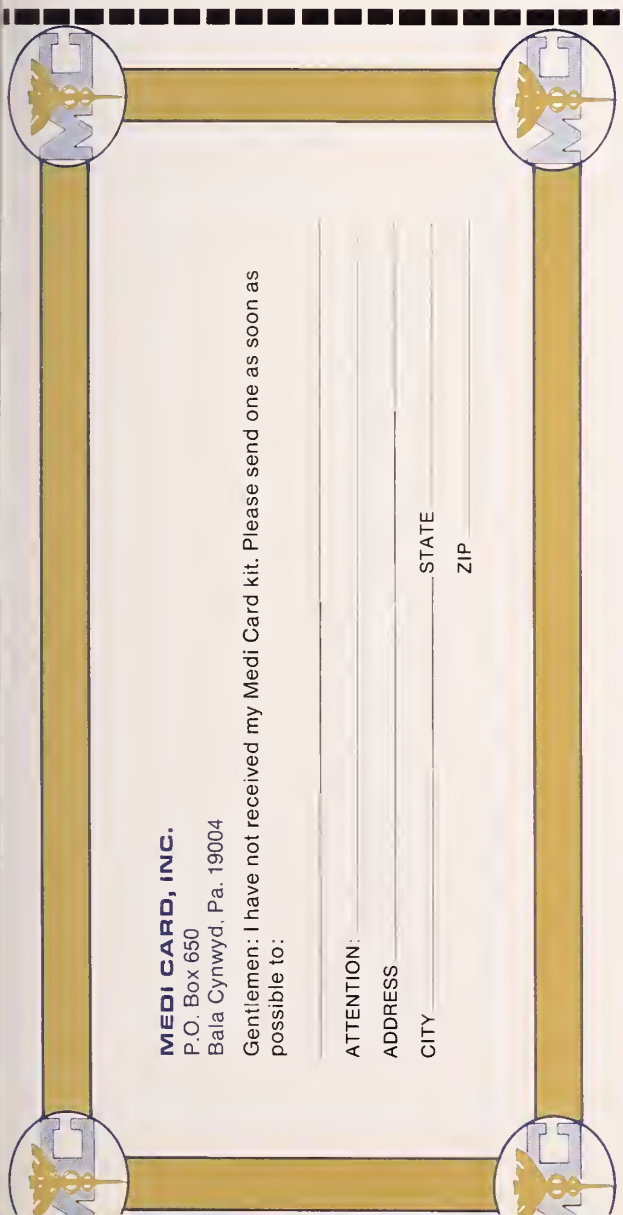
'hat is included in my professional Medi Card kit?

our kit contains complete information and instructons on how Medi Card works, 100 drafts, a plaque ating you accept Medi Card and 200 application rms.

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hyoscyamine sulfate	0.1037 mg.	0.1037 mg.	0.3111 mg.
atropine sulfate	0.0194 mg.	0.0194 mg.	0.0582 mg.
hyoscine hydrobromide	0.0065 mg.	0.0065 mg.	0.0195 mg.
phenobarbital	(¼ gr.) 16.2 mg.	(½ gr.) 32.4 mg.	(¾ gr.) 48.6 mg.
(Warning: may be habit forming)			

Brief Summary. Blurring of vision, dry mouth, difficult urination, and flushing or dryness of the skin may occur on higher dosage levels, rarely on usual dosage. Administer with caution to patients with incipient glaucoma or urinary bladder neck obstruction. Contraindicated in acute glaucoma, advanced renal or hepatic disease or a hypersensitivity to any of the ingredients.

A. H. ROBINS COMPANY, RICHMOND, VIRGINIA 23220

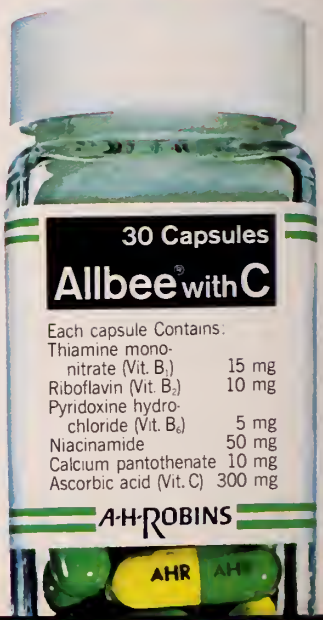
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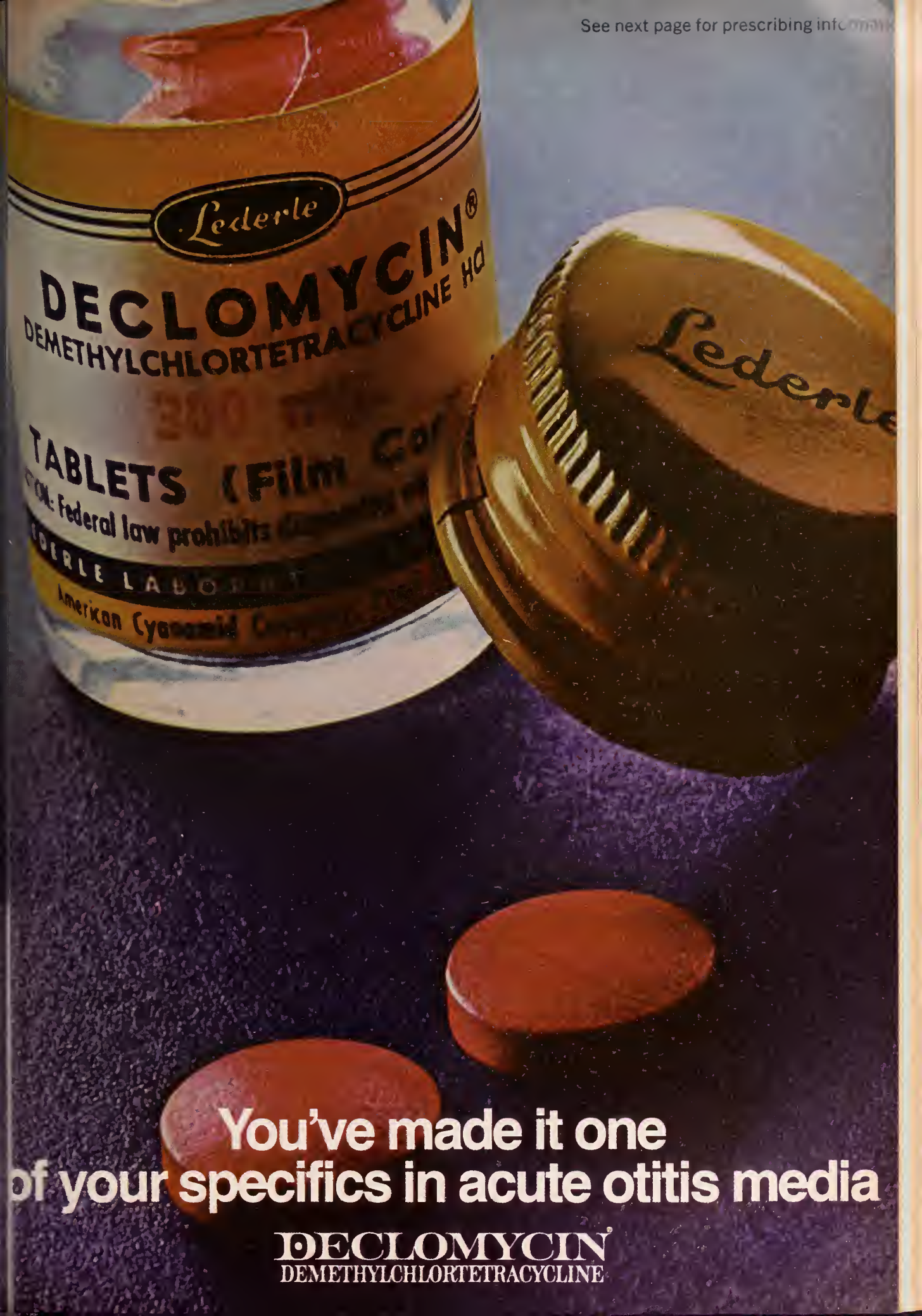
290 tangerines or 30 Allbee® with C.

Your patient would have to peel and eat 290 tangerines a month, almost 10 every day, to get as much Vitamin C as is contained in just one bottle of 30 Allbee with C capsules (taken one capsule daily). In addition, each capsule provides full therapeutic amounts of the B-complex vitamins. For example, as much niacin as 2 pounds of sirloin steak. This handy bottle of 30 Allbee with C capsules gives your patient a month's supply at a very reasonable cost. Also the economy size of 100. Available at pharmacies on your prescription or recommendation.



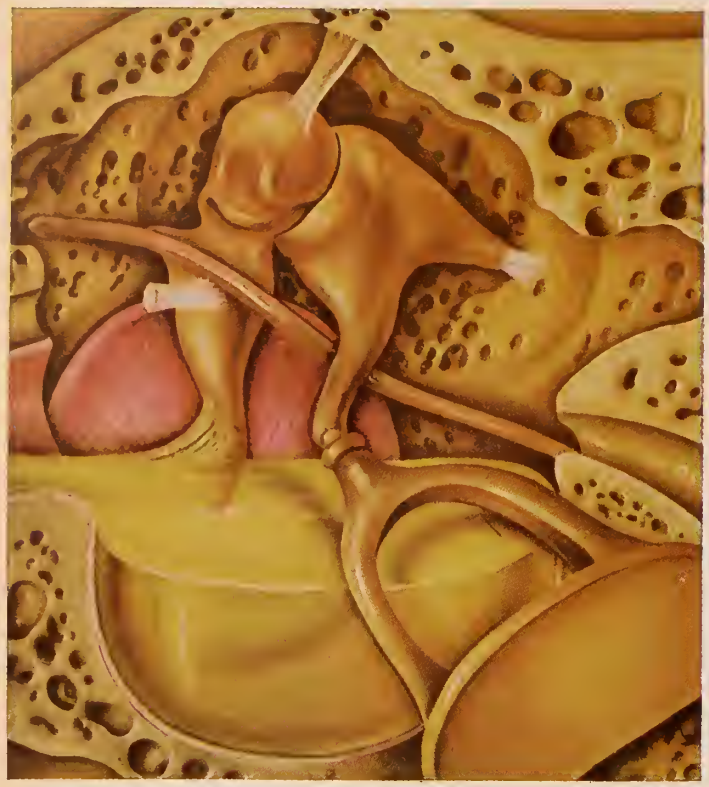
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See next page for prescribing info



You've made it one of your specifics in acute otitis media

DECLOMYCIN®
DEMETHYLCHLORTETRACYCLINE



You've made it one of your specifi(s) in acute otitis medi(a)

DECLOMYCIN acts against many strains of H. influenzae, pneumococci and streptococci, t(he) most common invaders. In otitis media, where i(t) is difficult to isolate the causative organism, th(e) coverage may be important. However, some stra(ins) may be resistant and other pathogens can be involved.

You've found the high serum levels of DECLOMYCIN important, too. Its prolonged act(ion) permits convenient 300 mg b.i.d. or 150 mg q.i.d. administration.

When specimens are obtainable, your culture studies will indicate the usefulness of DECLOMYCIN.

Effectiveness: DECLOMYCIN Demethylchlortetracycline should be equally or more effective therapeutically than other tetracyclines in infections caused by organisms sensitive to the tetracyclines.

Contraindication: History of hypersensitivity to demethylchlortetracycline.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocol(itis), pruritus ani. Skin—maculopapular and erythematous rashes; a(n) case of exfoliative dermatitis has been reported. Photosensiti(vity), onycholysis and discoloration of the nails (rare). Kidney—rise in B(UN), apparently dose-related. Transient increase in urinary output, so(me)times accompanied by thirst (rare). Hypersensitivity reactions—u(rti)caria, angioneurotic edema, anaphylaxis. Teeth—dental staining (y)ellow-brown) in children of mothers given this drug during the latter h(alf) of pregnancy, and in children given the drug during the neonatal p(eri)od, infancy and early childhood. Enamel hypoplasia has been see(n) in a few children. If adverse reaction or idiosyncrasy occurs, discontin(ue) medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tis(sue) with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Sho(uld) be given 1 hour before or 2 hours after meals, since absorption impaired by the concomitant administration of high calcium cont(aining) drugs, foods and some dairy products. Treatment of streptococc(al) infections should continue for 10 days, even though symptoms ha(ve) subsided.

DECLOMYCIN®
DEMETHYLCHLORTETRACYCLINE

Capsules: 150 mg; **Tablets:** film coated, 3(00) mg, 150 mg and 75 mg of demethylchlortet(racy)cline HCl.

3

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American Cyanamid Company, Pearl River, New York

Lederle



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Help the healing process with StomAseptine® douching

Helps flush away exudates, maintain internal cleanliness, reduce odor...reassures the patient

StomAseptine douching is a valuable adjunct to cervicitis therapy. These gentle, non-irritating internal irrigations help maintain a clear field by washing away pus and secretions...relieve itching and burning...reduce malodor...and offer the patient a refreshing, reassuring procedure that can help speed the healing process.



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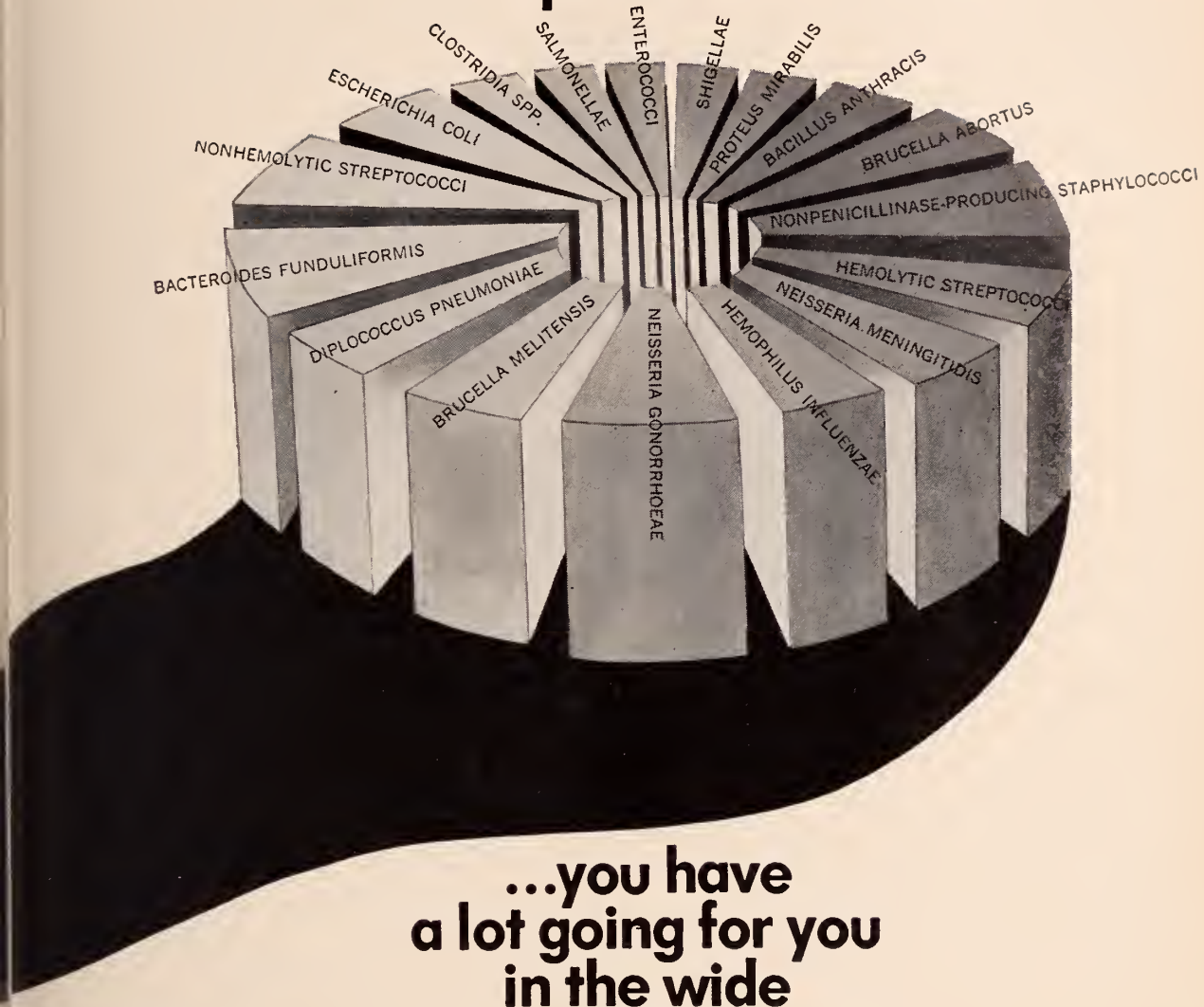
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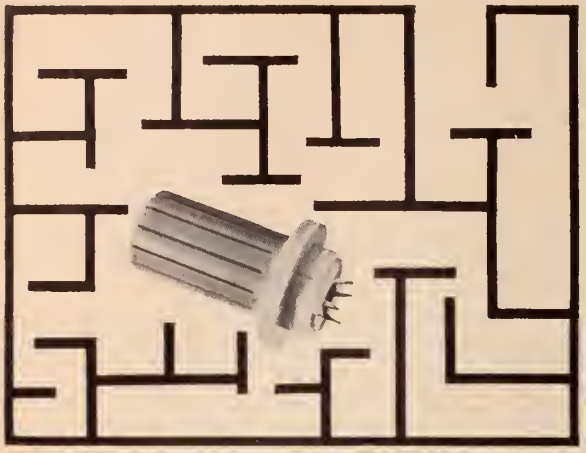
PRESCRIBING INFORMATION. For complete information consult Official Package Circular.
Indications: Infections due to susceptible strains of Gram-negative bacteria (including Shigellae, *S. typhosa* and other Salmonellae, *E. coli, H. influenzae, P. mirabilis, N. gonorrhoeae* and *N. meningitidis*) and Gram-positive bacteria (including streptococci, pneumococci and nonpenicillinase-producing staphylococci).
Contraindications: A history of allergic reactions to penicillins or cephalosporins and infections due to penicillinase-producing organisms.
Precautions. Typical penicillin-allergic reactions may occur, especially in hypersensitive patients. Mycotic or bacterial superinfections may occur. Experience in newborn and premature infants is limited and caution should be used in treatment, with frequent organ function evaluations. Safety for use in pregnancy is not established. In gonorrheal therapy, serologic tests for syphilis should be performed initially and monthly for 4 months. Assess renal, hepatic and hematopoietic function intermittently during long-term therapy.
Adverse Reactions: Skin rash, pruritus, urticaria, nausea, vomiting, diarrhea and anaphylactic reactions. Mild transient elevations of SGOT or SGPT have been noted. Black tongue has been noted in some patients receiving the Chewable Tablets.
Usual Dosage: Adults—250 or 500 mg. q. 6 h. (according to infection site and offending organisms). Children—50-100 mg./Kg./day in 3 to 4 divided doses (depending on infection site and offending organisms). Bacterial meningitis —150-200 mg./Kg./day in 6 to 8 divided doses. Children weighing more than 20 Kg. should be given an adult dose when prescribing orally. In parenteral administration, children weighing more than 40 Kg. should be given an adult dose. Beta-hemolytic streptococcal infections should be treated for at least 10 days.
Supplied: Capsules—250 mg. in bottles of 24 and 100. 500 mg. in bottles of 16 and 100. For Oral Suspension—125 mg./5 ml. in 60, 80 and 150 ml. bottles. 250 mg./5 ml. in 80 and 150 ml. bottles. Chewable Tablets—125 mg. in bottles of 40. Injectable—for I.M./I.V. use—vials of 125 mg., 250 mg., 500 mg., and 1 Gm. Pediatric Drops—100 mg./ml. in 20 ml. bottles.
11-1/2/69 **A.H.F.S. Category 8:12.16**

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Division of Bristol-Myers Co.
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Precautions—Nonspecific reactions are rare, but may occur. Vesiculation, ulceration or necrosis may occur at test site in highly sensitive persons. The test should be used with caution in patients known to be allergic to acacia, or to thimerosal (or other mercurial compounds).

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A Division of American Cyanamid Company, Pearl River, New York
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this ulcer did not heal...until its surface was cleared of dead tissue and debris



FIRST APPLICATION
ELASE Ointment is applied to a deep ulceration of a finger.

EIGHTEEN DAYS LATER
Healing has progressed rapidly without interruption or interference from any accumulated purulence or necrotic tissue. Greatly reduced size of lesion and minimal scar tissue indicate quality and vigor of healing which is almost complete.



to aid in debridement to facilitate healing in chronic cutaneous ulcers...

Elase® ointment

(fibrinolysin and desoxyribonuclease, combined, [bovine] ointment)

PARKE-DAVIS

By helping to remove dead tissue and debris from the ulcer's surface, ELASE Ointment creates a better environment for the elimination of infection, for healthy granulation... *for healing.* Its lytic enzymes effectively break down DNA in dead leukocytes and other debris... the fibrin in blood clots, serum, and purulent exudates... and the denatured proteins in necrotic tissue. Protein elements of *living* tissue are relatively unaffected. ELASE Ointment is indicated in stasis ulcers and in other infected or inflamed ulcers caused by circulatory disturbances. In cases requiring skin grafting, it is used preoperatively for debridement. For ambulatory patients debridement with ELASE Ointment is a convenient therapy and a regimen likely to be followed. *Precautions:* Observe usual precautions against allergic reactions, particularly in persons with a history of sensitivity to materials of bovine origin or to mercury compounds. *Adverse Reactions:* Side effects attributable to the enzymes have not been a problem at the dose and for the indications recommended. *Discussion:* Successful use of enzymatic debridement depends on several factors: (1) dense, dry eschar, if present, should be removed surgically before enzymatic debridement is attempted; (2) the enzyme must be in constant contact with the substrate; (3) accumulated necrotic debris must be periodically removed; (4) the enzyme must be replenished at least once daily; and (5) secondary closure or skin grafting must be employed as soon as possible after optimal debridement has been attained. It is further essential that wound-dressing techniques be performed carefully under aseptic conditions and that appropriate systemically acting antibiotics be administered concomitantly if, in the opinion of the physician, they are indicated. *Available:* ELASE Ointment is supplied in 30-Gm. tubes containing 30 units (Loomis) of fibrinolysin and 20,000 units of desoxyribonuclease with 0.12 mg. thimerosal (mercury derivative); and in 10-Gm. tubes containing 10 units of fibrinolysin and 6,666 units of desoxyribonuclease with 0.04 mg. thimerosal. ELASE Ointment has a special base of liquid petrolatum and polyethylene; contains sodium chloride and sucrose used during manufacture; is stable at room temperature through the expiration date stated on the package.

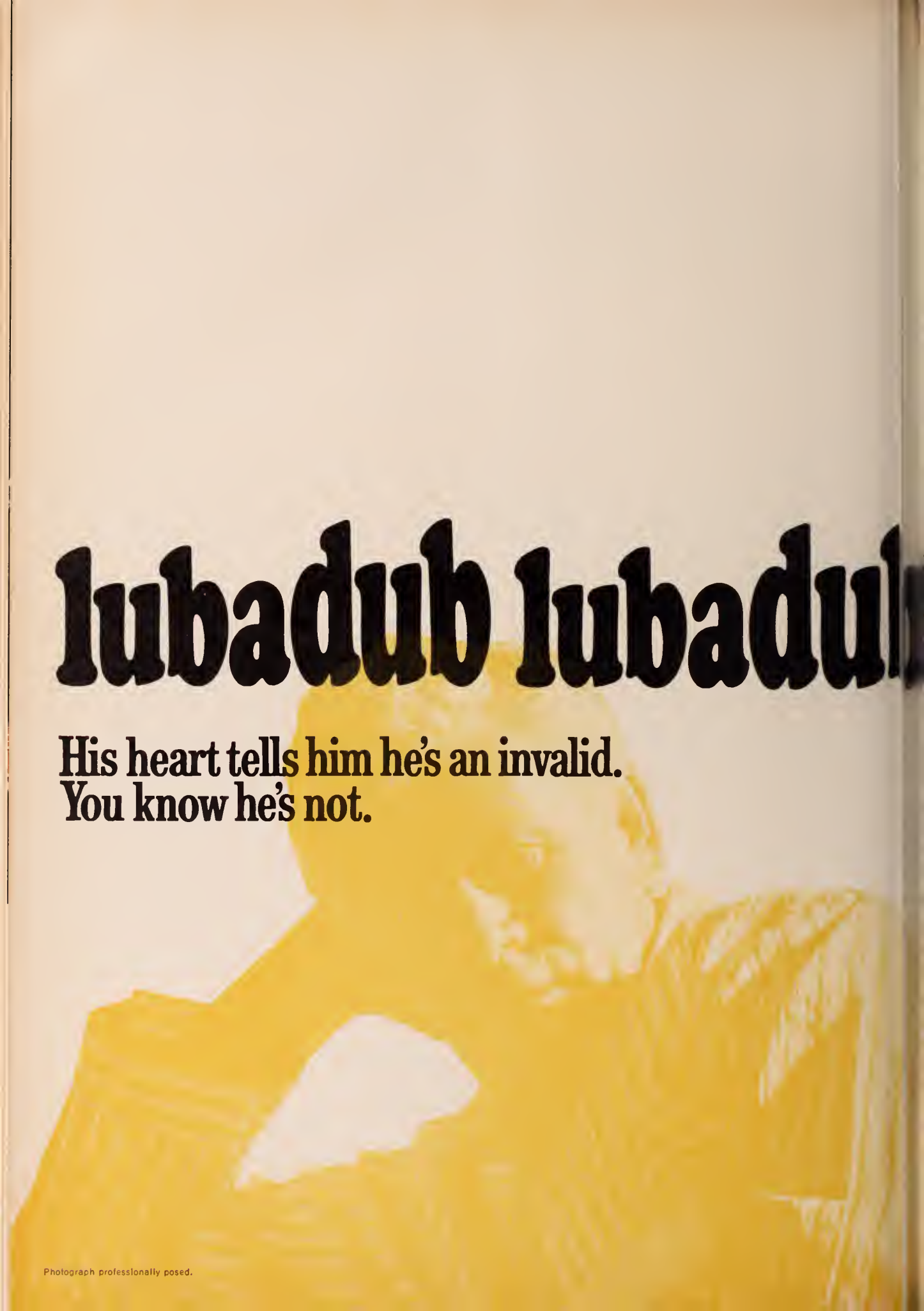
Parke, Davis & Company, Detroit, Michigan 48232

PARKE-DAVIS

48168

lubadub lubadub

His heart tells him he's an invalid.
You know he's not.



Photograph professionally posed.

Contraindications: History of sensitivity to meprobamate.

Important Precautions: Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use has been reported to result in dependence or habituation in susceptible persons, as alcoholics, ex-addicts, and other severe psychoneurotics. After prolonged excessive dosage, reduce dosage gradually to avoid possibly severe withdrawal reactions. Abrupt discontinuance of excessive doses has sometimes resulted in epileptiform seizures.

Warn patients of possible reduced alcohol tolerance, with resultant slowing of reaction time and impairment of judgment and coordination.

Reduce dose if drowsiness, ataxia or visual disturbance occurs; if persistent, patients should not operate vehicles or dangerous machinery.

Side Effects include drowsiness, usually transient; if persistent and associated with ataxia, usually responds to dose reduction; occasionally concomitant CNS stimulants (amphetamine, mephentermine sulfate) are desirable. Allergic or idiosyncratic reactions are rare, but such reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Previous history of allergy may or may not be related to incidence of reactions. Mild reactions are characterized by itchy urticarial or erythematous maculopapular rash, generalized or confined to groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. One fatal case of bullous dermatitis following intermittent use of meprobamate with prednisolone has been reported. If allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis,

ıbadubdub lubadı

xiety is expected in the cardiovascular patient.
little may even be desirable.

ıt when anxiety is exaggerated . . . when it
erferes with sleep . . . when it aggravates
rdiovascular symptoms, your help may
needed.

turally, you'll want to reassure the patient.

d perhaps prescribe Equanil (meprobamate)
adjunctive therapy. It helps relieve anxiety
d tension specifically, yet gently.

most 15 years' use has shown that Equanil
usually well tolerated as well as effective.
de effects are generally limited to transient
owsiness; serious, therapy-interrupting
de effects are rare.

stomatitis and proctitis (1 case) and hyperthermia. Treat symptomatically as with epinephrine, antihistamine and possibly hydrocortisone. Aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia have occurred rarely, almost always in presence of known toxic agents. A few cases of leukopenia, usually transient, have been reported on continuous administration.

Meprobamate may sometimes precipitate grand mal attacks in patients susceptible to both grand and petit mal. Extremely large doses can produce rhythmic fast activity in the cortical pattern. Impairment of accommodation and visual acuity has been reported rarely. After excessive dosage for weeks or months, withdraw gradually (1 or 2 weeks) to avoid recurrence of pretreatment symptoms (insomnia, severe anxiety, anorexia). Abrupt discontinuance of excessive doses has sometimes resulted in vomiting, ataxia, tremors, muscle twitching and epileptiform seizures. Prescribe very cautiously and in small amounts for patients with suicidal tendencies. Suicidal attempts have resulted in coma, shock, vasomotor and respiratory collapse and anuria. Excessive doses have resulted in prompt sleep; reduction of blood pressure, pulse and respiratory rates to basal levels; and occasionally hyperventilation. Treat with immediate gastric lavage and appropriate symptomatic therapy. (CNS stimulants and pressor amines as indicated.) Doses above 2400 mg./day are not recommended.

Composition: Tablets, 200 mg. and 400 mg. meprobamate. Coated Tablets, WYSEALS® EQUANIL (meprobamate) 400 mg. (All tablets also available in REDIPAK® [strip pack], Wyeth.) Continuous-Release Capsules, EQUANIL L-A (meprobamate) 400 mg.

Wyeth Laboratories Philadelphia, Pa.

Equanil®
(meprobamate) Wyeth®


P
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P
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A little sunshine for summer cold and allergy sufferers.

Novahistine LP can brighten things in a hurry for your summer cold and allergy patients.
These continuous-release, decongestant tablets contain a vasoconstrictor-antihistamine formulation that goes to work promptly and usually provides effective relief even in those cases of nasal congestion caused by repeated allergic episodes.
And, convenient twice-a-day dosage with Novahistine LP lets most patients enjoy relief all day and all night.
Use with caution in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result.

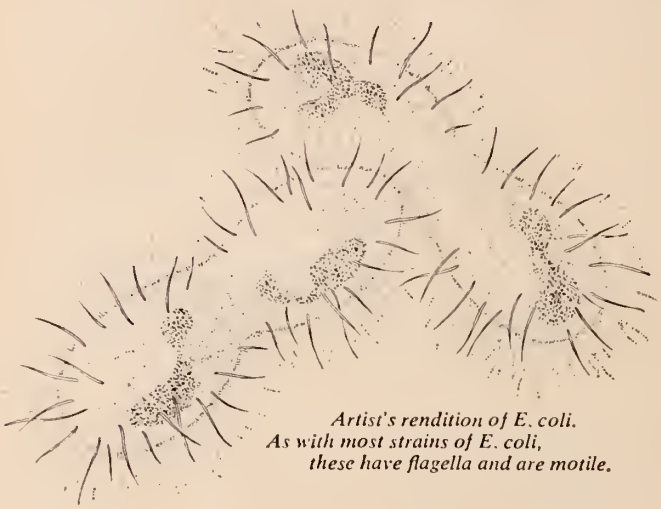
PITMAN-MOORE Division of
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Indianapolis, Indiana.

Novahistine®
LP decongestant

(Each tablet contains 25 mg. of phenylephrine hydrochloride and 4 mg. of chlorpheniramine maleate.)

DOW

To help avert chronicity in acute cystitis



Artist's rendition of E. coli. As with most strains of E. coli, these have flagella and are motile.

Although it may coexist wi
chronic pyelonephritis or prost
titis, many cases of chronic cys
tis may result from incomple
treatment of a simple, acute cys
tis. For this reason, it is bei
increasingly recommended th
appropriate antibacterial thera
in full dosage be maintained f
up to two weeks or longer.

Most frequently, the domina
pathogen is gram-negative, us
ally *E. coli;* most often, you wi
find Gantanol® (sulfametho
azole) effective against *E. co*
and other sensitive organisms
gram-positive and gram-negati
—commonly seen in cystitis an
other urinary tract infection
Wide clinical usage of Gantan
has confirmed the efficacy of th
wide-spectrum antimicrobi
agent in the treatment of cystiti

The rapidity of bacterial mu
tiplication in a favorable urina
environment is well know
Prompt control of acute bladde
infection is therefore essenti

Before prescribing, please consult con
plete product information, a summary
which follows:

Indications: Acute and chronic urina
tract, respiratory and soft tissue infe
tions due to susceptible microorganism
prophylactically following diagnostic i
strumental procedures on genitourina
tract.

Contraindicated in sulfonamide-sensiti
patients, pregnant females at term, pr
mature infants, or newborn infants du
ing first 3 months of life.

Warnings: Use only after critical ap
praisal in patients with liver or ren
damage, urinary obstruction or bloo
dyscrasias. Deaths reported from hy
persensitivity reactions, Stevens-Johnso
syndrome, agranulocytosis, aplastic an
mia and other blood dyscrasias. In closel
intermittent or prolonged therapy, bloo
counts and liver and kidney function tes
should be performed. Clinical data insu
ficient on prolonged or recurrent therap
in chronic renal diseases of children un
der 6 years.

Precautions: Occasional failures may oc
cur due to resistant microorganisms. No
effective in virus and rickettsial infe
tions. Sulfonamides not recommende

not only to reduce the patient's discomfort but to prevent chronicity and possible ascending infection.

Gantanol (sulfamethoxazole) provides antibacterial activity within two hours of the initial 2-Gm dose, and subsequent 1-Gm doses, taken morning and evening, maintain therapeutic blood and urine levels lasting up to 12 hours. Significant symptomatic response is frequently achieved within 24 to 48 hours in acute, uncomplicated cystitis and other responsive urinary tract infections. In addition, Gantanol is usually well tolerated. Should prolonged therapy be required, the convenient *b.i.d.* dosage helps to minimize the problem of skipped doses.

Over eight years' clinical use has thoroughly demonstrated the qualities that make Gantanol a good choice for initial therapy of most urinary tract infections, including acute cystitis.

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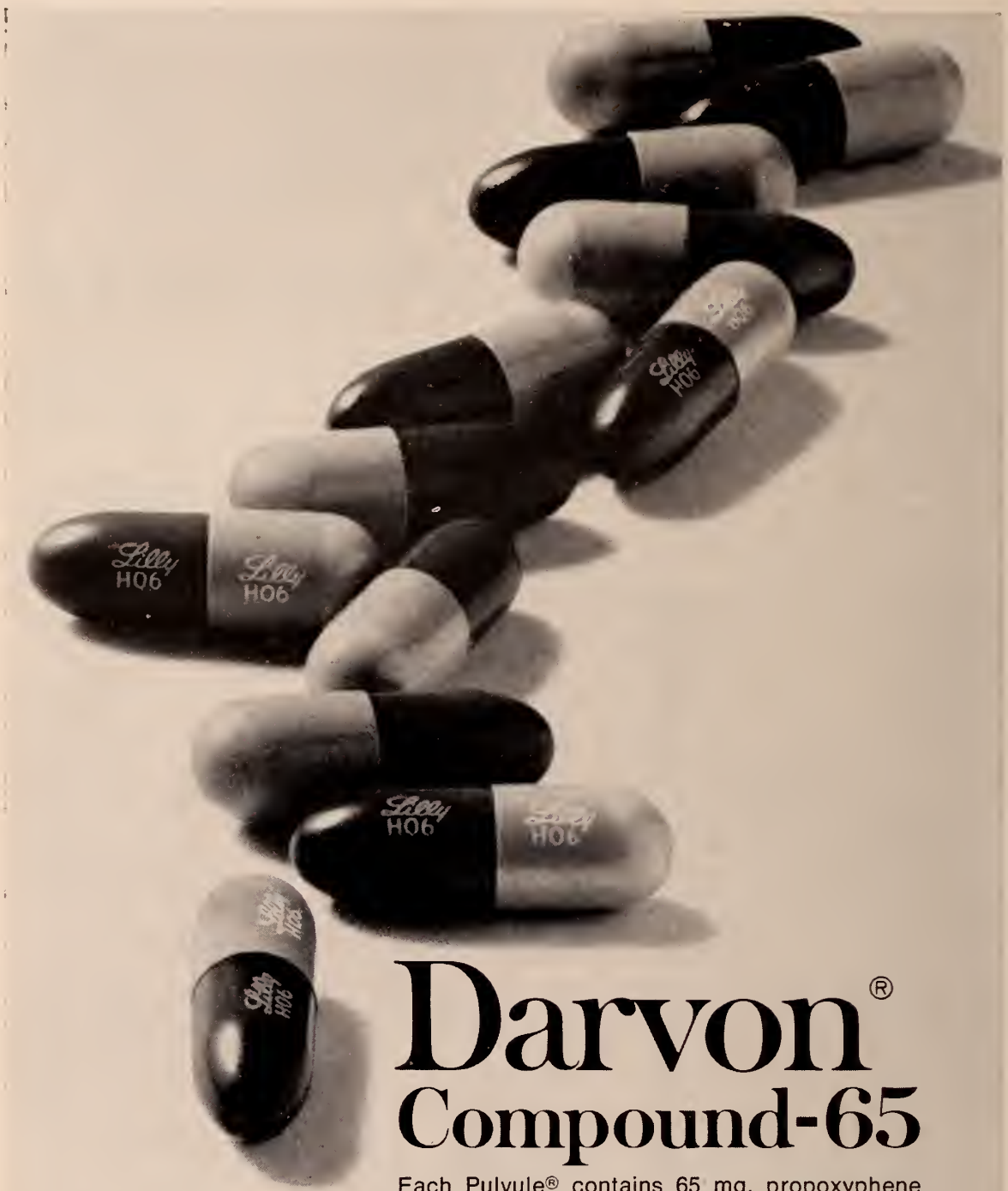
for therapy of acute infections caused by group A beta-hemolytic streptococci. At present, penicillin is drug of choice in acute group A beta-hemolytic streptococcal infections; although Gantanol has produced favorable bacteriologic conversion rates in this infection, data insufficient on long-term follow-up studies as to its effect on sequelae of rheumatic fever or acute glomerulonephritis. If other treatment cannot be used and Gantanol is employed in such infections, *important that therapy be continued in usual recommended dosage for at least 10 days.* Observe usual sulfonamide therapy precautions, including adequate fluid intake. Use with caution if history of allergies and/or asthma. Follow closely patients with renal impairment since this may cause excessive drug accumulation. Need for indicated local measures or surgery not obviated in localized infections.

Adverse Reactions: Depending upon the severity of the reaction, may withdraw drug in event of headache, nausea, vomiting, urticaria, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, Stevens-Johnson syndrome, skin rash, injection of the conjunctiva and sclera, petechiae, purpura, hematuria and crystalluria.

Gantanol®
(sulfamethoxazole) assures rapid, sustained, antibacterial activity with b.i.d. dosage

Gantanol® B.I.D.
(sulfamethoxazole)

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LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110



Darvon®
Compound-65

Each Pulvule® contains 65 mg. propoxyphene hydrochloride, 227 mg. aspirin, 162 mg. phenacetin, and 32.4 mg. caffeine.

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EDITORIALS

Eternal Hope And Hard Facts

The history of medicine is encumbered by panaceas that didn't work. From Jenkins metallic tractors (praised by George Washington in the 1770s as having the mineral magnetism to withdraw the evil) to the newest fads and diets, there is a long and pathetic list. Only recently, someone developed an elaborate routine of crawling, creeping, and limb manipulation to "build up the neurologic potential" of brain-damaged children. It has been rejected by most of the top professional and citizens' organizations in the field, and the May 27, 1968 *AMA News* detailed this criticism. One rather touching point is that when a father or mother indicates skepticism or reluctance, the parent is put into the position of being told that he doesn't care about his child. One can cite a long list of special diets, each with a devoted coterie of supporters. Cancer cures have been with us since the turn of the century.

In a way, we are on the horns of a dilemma. Just as they once laughed at Christopher Columbus, so they laughed at the possibilities of penicillin and the sulfa drugs. While neither continental discoveries nor effective wonder drugs come along very often, there is always the fear that this time, the proposal will make sense. What lends unsupported and unproved theories their special poignancy is that families are so desperate that they will try anything. The doctor, when asked about a new treatment for schizophrenia, carcinoma, arthritis, or mental deficiency, may point out that the regime proposed is unscientific and illogical. The family have a simple retort: do you have any method that will cure my child of schizophrenia, of a malignant tumor of the eye, of mental deficiency, of spastic paralysis? And when the honest physician admits that he doesn't, the family then ask: what have we to lose by trying this new method, if you have nothing better to offer?

When facts are hard, the physician finds is difficult to be too logical . . . or maybe he finds it easy. Probably every practitioner himself would grasp at a straw if it might, just might, save the life of a loved one, and if he had nothing to lose.

There is only one chance in 600 billion of getting a 13-card hand, all in spades. That's true: one chance in 600 billion. But then, you also had only one chance in 600 billion of getting the exact hand that you did draw.

Experts disagree as to whether Pandora's box was originally filled with evils or with blessings. But either way, it *is* agreed that when everything else left the box, one blessing indeed did remain. Its name was hope.

The Ultimate Tranquilizer

More than 100 fine pharmaceutical houses make drugs for administration to human beings. A few years ago, only three or four companies were making tranquilizers. These products were quite successful—so other manufacturers tried to share in the tranquilizer market. One of the beauties of our American free enterprise system is that competition spurs each to make something a little better. If the drug has too many side-effects, a competitor strives to develop a drug with fewer, or milder, untoward effects. If too large a dose is required, another competitor aims at a concentrated form of the drug so that the dose may be reduced. If one tranquilizer sedates too much, another company sets its sights at a nonsedative tranquilizer.

It is a beautiful system, and when it reaches the end of the line it will have produced the ultimate tranquilizer. This will make us feel calm. It will remove fear of failure. It will throw up a selective blanket which will shield us from the winds of ill-fortune. It will bleach out tension in the drive to accomplish. It will lend a rosy tint to the garish yellow of reality, as well as a pink coloration to what otherwise might be the blues. We will never again

crusade for the right, because to be a crusader you must feel tension. We will accept evil with a shrug, for in a fully tranquilized culture, there is always calm. Everywhere there will be peace, for peace is but the plural of individual tranquility. No one will get worked up over nothing, or over something. We will all realize Sydney Smith's boon: "A man does not choose to be disturbed. He is more thankful to the one who confirms him in his errors and leaves him alone than to the man who instructs him at the expense of his tranquility."

Under the benign bedspread of the ultimate tranquilizer, we will all come to rest. Gone will be the spur to invention, the drive to reform, the divine dissatisfaction that leads to progress. So we will rest, smiling at each other in the beatific calm of the ultimate tranquilizer, until some neighboring tribe, some rude and primitive people, move in on us. They will vanquish us with ease, because no one ever thought of giving the tranquilizer to our enemies as well as to our friends. And when the dust over our civilization stops being radio-active, a 30th century archeologist will find on the tombstone of our culture: "Here lies the tranquil man."

The Last Horseman

For centuries, infection was the great killer. A cut finger might lead to "blood poisoning" and all the art of the doctor and the heartbreaking vigil of the family were useless. The animalcules multiplied and killed the host. And now we have reason to hope that the fear of infection may, by the end of our children's generation, be substantially banished.

Infection slaughtered men and women and children. It had many names. It was the black death, the great plague. It was typhus and cholera. It was childbed fever. It haunted the halls of ancient hospitals striking down postoperative victims, the just and the unjust alike. It was the great pandemic, the scourge, the last horseman of the apocalypse. Indeed the number one cause of death was, for centuries, not heart disease, not cancer, not war, but malaria.

Infection stole away our children. Measles killed and so did scarlatina. Children were maimed by small-pox, ruptured their alveoli with whooping cough, and choked to death on diphtheritic membranes. Tuberculosis was the white plague and bubonic fever the black plague.

And then we began to attack these big little germs. The "we" does not mean just physicians. It included doctors of course — practitioners at the bedside, research physicians in the laboratory, public health doctors in the field. Engineers drained swamps, entomologists trapped mosquitoes, government officials threw the full weight of their approval behind health campaigns. The medical schools joined. The pharmaceutical industry did primary research and wrought miracles of production. Magazines and newspapers spread public education in the health field. Slum clearance workers eradicated many sources of infection. Health officers at every level joined in the crusade.

And it paid off. The infectious tide has receded. Children now are more threatened by automobiles than by bacteria. Millions saved from early death due to infection, have been preserved to die from cardiovascular disease or malignancy. Since all men are mortal, our accomplishments do not conquer death, they merely delay it.

Our triumph over infection is not complete. With the new assurance goes a new carelessness. Operating room discipline becomes lax as we become contumacious towards infection. And then the rate goes up. Tuberculosis hospitals get smaller, and more tuberculous patients are free in the community. Asepsis seems less important, so we grow careless. But the bright hope remains. We know that never again will a death warrant be written with the words, "infection has set in." If we do not throw away our triumph, we shall finally destroy this last horseman.

203rd ANNUAL MEETING

The Medical Society of New Jersey

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John F. Kustrup, M.D.
President

Jerome G. Kaufman, M.D.
Chairman, Annual Meeting Committee

Milton Ackerman, M.D.
Chairman, Scientific Exhibits

James A. Rogers, M.D.
Chairman, Scientific Program

Marion R. Walton
Convention Manager

May 17-20, 1969
Chalfonte-Haddon Hall
Atlantic City

1969 Annual Meeting

RÉSUMÉ OF EVENTS

Saturday through Tuesday
May 17 to 20, 1969

Chalfonte-Haddon Hall
Atlantic City

Registration

Saturday, May 17 from 10:00 a.m. to 4:30 p.m. Sunday, Monday, and Tuesday, May 18, 19, and 20, from 9:00 a.m. to 4:30 p.m.

Golden Merit Award

Saturday, May 17 at 1:00 p.m. Honored will be those members of MSNJ who have held the degree of Doctor of Medicine for fifty years. Reception following ceremony.

House of Delegates

First session—Saturday, May 17 at 3:00 p.m.
Second session—Sunday, May 18 at 2:30 p.m. (Election)
Third session—Tuesday, May 20 at 9:00 a.m.

Medical-Surgical Plan

Saturday, May 17—At the close of the first session of the House of Delegates there will be an open discussion on the Medical-Surgical Plan.

"The Concept"—Live Theatre

Saturday, May 17 at 9:00 p.m.—Off-Broadway production presented in cooperation with the Bureau of Narcotic Addiction and Drug Abuse and the Division of Mental Health and Hospitals, New Jersey Department of Institutions and Agencies. The entire cast consists of members of Daytop Village.

Special Session

Sunday, May 18 at 9:30 a.m.—Session on the Diagnosis of Life and Death, presented by the Academy of Medicine of New Jersey.

Exhibits

Informational—Scientific—Technical
Sunday, May 18 from 10 a.m. to 5 p.m. Monday and Tuesday, May 19 and 20, from 9 a.m. to 5 p.m.

Reference Committees

Sunday, May 18 at 10:45 a.m.
(Coffee-Meeting with Chairmen at 10:00 a.m.)

Motion Picture Theatre

Sunday, Monday and Tuesday, May 18, 19 and 20, starting 10:00 a.m. and again at 2:00 p.m.—Arranged and presented through the cooperation of Ciba Pharmaceutical Company, Summit.

General Session

Sunday, May 18 at 4:00 p.m. Address of Incoming President, Dr. Nicholas A. Bertha.

"The New Jersey Medicaid Program," Lloyd W. McCorkle, Ph.D., Commissioner, New Jersey State Department of Institutions and Agencies.

Reception for President-Elect

Sunday, May 18 at 6:00 p.m. Members, guests, wives of members and guests, and Auxiliary members are invited to attend a reception honoring the President-Elect, Dr. Nicholas A. Bertha. (Admission by badge)

Exhibitors Reception-Buffet

Sunday, May 18 at 8:00 p.m. Reception and buffet honoring technical exhibitors. (Tickets may be purchased at Registration Desk—$8)

Scientific Program

Scientific Section Sessions:
Monday, May 19 at 9:30 a.m. and at 2:00 p.m.
Tuesday, May 20 at 9:30 a.m. and at 2:00 p.m.

Dinner-Dance

Monday, May 19 at 7:00 p.m. Members, guests, wives of members and guests, and Auxiliary members are invited to attend a dinner-dance in honor of President and Mrs. John F. Kustrup. (Tickets at Registration Desk—$10)

Miscellaneous

Saturday, May 17 at 1:00 p.m.—New Jersey Committee on Trauma, American College of Surgeons.

Saturday, May 17 at 7:00 p.m.—Officers' Dinner. (By invitation only)

Sunday, May 18 at 12 noon—Luncheon, New Jersey Medical Women's Association.

Monday, May 19 at 12:30 p.m.—Luncheon, New Jersey Allergy Society.

Monday, May 19 at 12:30 p.m.—Luncheon, New Jersey Chapter, American Academy of Pediatrics.

Monday, May 19 at 12:30 p.m.—Luncheon, New Jersey Chapter, American College of Chest Physicians.

Monday, May 19 at 12:30 p.m.—Luncheon, New Jersey Orthopedic Society.

Monday, May 19 at 3:00 p.m.—Meeting, New Jersey Society for Physical Medicine and Rehabilitation.

Monday, May 19 at 5:30 p.m.—Reception, Jefferson Medical College Alumni.

Tuesday, May 20 at 12 noon—Luncheon, MSNJ Section on Cardiovascular Diseases.

1969 Annual Meeting

DAILY SCHEDULE

Saturday through Tuesday
May 17 to 20, 1969

Chalfonte-Haddon Hall
Atlantic City

Friday / May 16, 1969

4:00 p.m.—Board of Trustees

Saturday / May 17, 1969

10:00 a.m.—Registration Opens
1:00 p.m.—Golden Merit Award Ceremony
followed by
Reception for Award Recipients and Their Families
1:00 p.m.—New Jersey Committee on Trauma
American College of Surgeons
3:00 p.m.—House of Delegates and President's Farewell Address
followed by
Open Discussion on Medical-Surgical Plan
4:30 p.m.—Nominating Committee
7:00 p.m.—Officers' Dinner
(by invitation only)
9:00 p.m.—"The Concept" — Off-Broadway Production
Presented by Bureau of Narcotic Addiction and Drug Abuse and Division of Mental Health and Hospitals, New Jersey Department of Institutions and Agencies
(All members, official guests, and their wives, and Auxiliary members are cordially invited to attend—admission by badge)

Sunday / May 18, 1969

9:00 a.m.—Registration Opens
9:30 a.m.—Special Session on Diagnosis of Life and Death
Presented by The Academy of Medicine of New Jersey
10:00 a.m.—Exhibits Open
10:00 a.m.—Coffee-Meeting with Reference Committee Chairmen
10:00 a.m.—Motion Picture Theatre
10:45 a.m.—Reference Committees
12 noon —Luncheon Meeting
New Jersey Medical Women's Association
"Psychiatric Problems and the Dying Patient"
Reservations: Mary T. Mazzarella, M.D., 50 Fielding Court, South Orange
2:00 p.m.—Motion Picture Theatre
2:30 p.m.—House of Delegates (election)
4:00 p.m.—General Session
Address of Incoming President
Address by Lloyd W. McCorkle, Ph.D., Commissioner, Department of Institutions and Agencies
"The New Jersey Medicaid Program"
(Open to all registered members and invited guests)
6:00 p.m.—Inaugural Reception Honoring President-Elect Bertha
(All members, official guests, and their wives, and Auxiliary members are cordially invited to attend—admission by badge)
8:00 p.m.—Reception — Buffet Dinner for Technical Exhibitors
(Tickets may be purchased at Registration Desk—$8)

Monday / May 19, 1969

9:00 a.m.—Registration and Exhibits Open
9:30 a.m.—Scientific Sessions:
Allergy, Metabolism
Chest Diseases, Clinical Pathology
Obstetrics and Gynecology, Radiology
Orthopedic Surgery
Otolaryngology
10:00 a.m.—Motion Picture Theatre
12:30 p.m.—Luncheon Meetings:
New Jersey Allergy Society
New Jersey Chapter, American Academy of Pediatrics
New Jersey Chapter, American College of Chest Physicians
New Jersey Orthopedic Society
2:00 p.m.—Scientific Sessions:
Anesthesiology, Pediatrics, Urology
Ophthalmology
Psychiatry and Neurology
Rheumatism
Surgery
2:00 p.m.—Motion Picture Theatre
3:00 p.m.—New Jersey Society for Physical Medicine and Rehabilitation
5:30 p.m.—Jefferson Medical College Alumni Reception
7:00 p.m.—Annual Dinner-Dance
(All members, official guests and their wives, and Auxiliary members are cordially invited to attend — tickets are $10 per person)

Tuesday / May 20, 1969

9:00 a.m.—Registration and Exhibits Open
9:00 a.m.—House of Delegates
9:30 a.m.—Scientific Sessions:
Cardiovascular Diseases
Gastroenterology and Proctology, General Practice
10:00 a.m.—Motion Picture Theatre
12 noon —Luncheon:
MSNJ Section on Cardiovascular Diseases
2:00 p.m.—Scientific Sessions:
Dermatology, Medicine
Plastic and Reconstructive Surgery
2:00 p.m.—Motion Picture Theatre
5:00 p.m.—Registration and Exhibits Close

Wednesday / May 21, 1969

8:30 a.m.—Board of Trustees

1969 Annual Meeting

GOLDEN MERIT AWARDS

Saturday, May 17 — 1:00 p.m.

Presiding

John F. Kustrup, M.D., President

Master of Ceremonies

John J. Crosby, Jr., M.D., Chairman, Council on Public Relations

Marshals

Presidents of Component Societies whose members are receiving awards

The Golden Merit Award, established in 1957, is conferred upon every member of The Medical Society of New Jersey who has held the degree of Doctor of Medicine for fifty years.

Recipients For 1969

County	Member
Atlantic	Frank W. W. Konzelmann, M.D.
Bergen	Herman C. Comora, M.D.
Burlington	Elizabeth F. Love, M.D.
Camden	Francis J. Warner, M.D.
Cumberland	Earl C. Lyon, M.D. Harry B. Walker, M.D.
Essex	Louis M. Bull, M.D. John C. Cox, M.D. Anthony B. Cucinella, M.D. Millard B. Ervin, M.D. F. Irving Ganot, M.D. James R. Irwin, M.D. Henry H. Kessler, M.D. Charles W. MacMillan, M.D. Samuel Orloff, M.D. Berta D. Rados, M.D. Harry A. H. Schachter, M.D. Herbert A. Schulte, M.D. George H. VanEmburgh, M.D.
Hudson	Herman Behrens, M.D. John J. Brozdowski, M.D. Harold J. Hoops, M.D. Israel Levine, M.D. Hugh A. McLean, M.D.* Lewis Schwartz, M.D. Adalbert Stein, M.D.
Mercer	Jacob J. Berman, M.D. Harold K. Doranz, M.D. Frank Kren, M.D. Carl L. Pierson, M.D.
Middlesex	Johannes F. Bielski, M.D. Pauline A. Long, M.D. John H. Rowland, M.D.
Monmouth	Otto R. Holters, M.D. Harold A. Kazmann, M.D. George S. Stevenson, M.D.
Passaic	Michael J. DeMattia, M.D. Francis R. Palmer, M.D.
Sussex	J. Earl Miles, M.D.
Union	Reuben J. Holland, M.D. Saivel L. Rosenstein, M.D.

Reception for Recipients and Families Following Ceremony

*Deceased.

1969 Annual Meeting

"THE CONCEPT"

(Live Theatre Presentation)

Saturday, May 17 — 9:00 p.m.

"The Concept" is a theatrical production arranged for and presented in cooperation with the Bureau of Narcotic Addiction and Drug Abuse and the Division of Mental Health and Hospitals, New Jersey Department of Institutions and Agencies.

"The Concept" is no ordinary play. Its cast consists of members of Daytop Village, a therapeutic community of ex-narcotics addicts. Its every word grows out of improvisations by these members, so that "The Concept" has not one playwright but nine playwrights—the eight performers and a professional director, a young man on Daytop Village's staff.

"The Concept" is the story of one person's drug addiction and how he overcame this addiction through his experience at Daytop Village. "The Concept" expresses in theatre terms the meaning of the Daytop way of life. The root of the problems of narcotics addiction is the lack of meaningful communication between people.

This play has been running at the Sheridan Square Playhouse since May 6, 1968, and the reviews have been excellent. Dan Sullivan, of the New York Times wrote, "It is not sentimental. The actors, none professional and all still at Daytop, use short blunt words that do not turn up on soap operas or in psychology books. The dialogue is very tough and very real. It is powerful theatre."

1969 Annual Meeting

SPECIAL SESSION

Diagnosis Of Life And Death

Sunday, May 18 — 9:30 a.m.

Arranged in cooperation with the Academy of Medicine of New Jersey.

9:30 a.m. / Coffee and Buns

9:45 a.m. / Symposium on Factors Leading to the Diagnosis of Life and Death

Panelists:

ARTHUR WINTER, M.D., Instructor of Neurosurgery, New Jersey College of Medicine and Dentistry; and Assistant Attending Neurosurgeon, St. Barnabas Medical Center, Livingston

A state of coma will usually precede death. A patient can return from coma to a useful life without neurologic deficit, or at times with some neurologic impairment. The approach of death and its criteria will be elaborated for more precise definition. The criterion of a flat electro-encephalogram for brain death, by itself, is not sufficient, but must be correlated with the entire range of clinical data.

CHRISTOPHER T. REILLY, M.D., Clinical Associate Professor of Gynecology and Obstetrics, New Jersey College of Medicine and Dentistry; and Attending in Gynecology and Obstetrics, The Valley Hospital, Ridgewood

Many aspects of biologic death, clinical death, brain death, organ death, social death, and theologic death will be discussed. The relationship of the subject to organ transplantation, heroic resuscitation, active treatment of cardiac arrest, legal establishment of the time of death, abortion, euthanasia, and other related ethical, medical, and legal problems will be reviewed. The responsibility of the physician-in-charge to determine when the respirator must be turned off and clinical death declared is a problem created by modern technology.

Professor WALTER R. MARTIN, Director, Christian Research Institute, Inc., Wayne; and Pastor, Van Riper Ellis Church, Fair Lawn

Summary not received

11:00 a.m. / Panel Discussion

11:30 a.m. / Visit to Exhibits

1969 Annual Meeting

General Session

Sunday, May 18 — 4:00 p.m.

Presiding

John F. Kustrup, M.D., President

Inaugural Address of Incoming President

Nicholas A. Bertha, M.D., Wharton
President-Elect

"The New Jersey Medicaid Program"

Lloyd W. McCorkle, Ph.D., Commissioner
New Jersey State Department
of Institutions and Agencies

1969 Annual Meeting

DINNER-DANCE

Monday, May 19 — 7:00 p.m.

Honoring

President and Mrs. John F. Kustrup

Guests — Governor and Mrs. Richard J. Hughes

Toastmaster

Richard I. Nevin

Welcome

Mrs. John F. Kustrup, President,
Woman's Auxiliary

Introductions

Mrs. Edward O. MacDonald, President-Elect,
Woman's Auxiliary
Nicholas A. Bertha, M.D., President-Elect

Presentations

Fellow's Key
To: John F. Kustrup, M.D.
By: Louis K. Collins, M.D.,
Immediate Past-President

Fellowette's Pin
To: Mrs. John F. Kustrup, President,
Woman's Auxiliary
By: John F. Kustrup, M.D., President

Entertainment

Marko Novosel, Baritone

Music and Dancing

Martin King Orchestra Associates

1969 Annual Meeting

REFERENCE COMMITTEES

Sunday, 10:45 a.m. May 18, 1969

Reference Committee on Constitution and Bylaws
Pennsylvania II, Lounge Floor

Reports of the:
- Committee on Revision of Constitution and Bylaws
- Amendments to Constitution
- Amendments to Bylaws

Reference Committee "A"
Room 1333, Tower Floor

Reports of the:
- President
- Board of Trustees
- Secretary
- Judicial Council
- Executive Director
- Committee on Credentials

Reference Committee "B"
Room 1344, Tower Floor

Reports of the:
- Treasurer
- Committee on Finance and Budget
- Committee on Publication
- Committee on Medical Student Loan Fund
- Committee on Project Hope/Vietnam

Reference Committee "C"
Mandarin Room, Tower Floor

Reports of the:
- Medical-Surgical Plan of New Jersey
- Committee on Medical Defense and Insurance
- Committee on Retirement Plan for Physicians

Reference Committee "D"
Room 1337, Tower Floor

Reports of the:
- Committee on Medical Education
- Committee on Medicine and Religion
- Committee on Emergency Medical Care
- Committee on Traffic Safety

Reference Committee "E"
West Room, Tower Floor

Reports of the:
- Council on Legislation
- Council on Medical Services, and its Special
- Committee on Occupational Health, Workmen's Compensation and Rehabilitation

Reference Committee "F"
Rutland Room, First Floor

Reports of the:
- Council on Public Relations
- Council on Mental Health, and its Special
- Committees on:
  - Alcoholism
  - Drug Abuse
  - Emotional Disorders of Childhood and Adolescence
  - Mental Retardation
  - Seizures

Reference Committee "G"
Derbyshire Room, First Floor

Reports of the:
- Council on Public Health, and its Special
- Committees on:
  - Air Pollution Control
  - Cancer Control
  - Child Health
  - Conservation of Vision
  - Maternal and Infant Welfare

Reference Committee "H"
Rowsley Room, First Floor

Reports of the:
- Committee on Annual Meeting, and its Special
- Committees on:
  - Scientific Exhibits
  - Scientific Program
- Committee on Honorary Membership
- Advisory Commitee to the Woman's Auxiliary

Nominations for Emeritus Membership

The Committee on Credentials will meet at the Registration Desk each morning of the meeting.

1969 Annual Meeting

HOUSE OF DELEGATES

Saturday, 3:00 p.m. — May 17, 1969
Sunday, 2:30 p.m. — May 18, 1969
Tuesday, 9:00 a.m. — May 20, 1969

President—John F. Kustrup, M.D., Trenton

Secretary—Marcus H. Greifinger, M.D., Newark

Speaker—Jesse McCall, M.D., Newton

Parliamentarian—Henry A. Davidson, M.D., East Orange

Sessions

Saturday, May 17—3:00 p.m.

First Session

Invocation
Very Reverend Monsignor Joseph A. O'Connor, Bishop's Representative, Fair Haven

Call to Order by the Speaker
Jesse McCall, M.D.

Organization of the House

Transactions of the 1968 House of Delegates

Introduction of Guests and Delegates from Other States

Annual and Supplemental Reports

Proposed Amendments to the Constitution and Bylaws

Resolutions

New Business

Announcements

President's Farewell Address

Sunday, May 18—2:30 p.m.

Second Session

Report of Nominating Committee

Election

(At the conclusion of this meeting of the House of Delegates a General Session on the New Jersey Medicaid Program will convene.)

Tuesday, May 20—9:00 a.m.

Third Session

Reports of Reference Committees

Unfinished Business

Adjournment

(Luncheon Recess—1:00-1:30 p.m.)

OFFICES TO BE FILLED BY ELECTION — 1969 ANNUAL MEETING

Office	Term	From To	Incumbent and County
President-Elect	1 year	May 1969-May 1970	Nicholas A. Bertha Morris
1st Vice-President	1 year	May 1969-May 1970	Emanuel M. Satulsky Union
2nd Vice-President	1 year	May 1969-May 1970	E. Vernon Davis Burlington
Secretary	1 year	May 1969-May 1970	Marcus H. Greifinger Essex
Treasurer	1 year	May 1969-May 1970	Samuel J. Lloyd Mercer
Trustees:			
1st District	3 years	May 1969-May 1972	(New Trusteeship)
	3 years	May 1969-May 1972	(New Trusteeship)
2nd District	3 years	May 1969-May 1972	Matthew E. Boylan Hudson
	3 years	May 1969-May 1972	(New Trusteeship)
3rd District	3 years	May 1969-May 1972	George E. Barbour Somerset
	3 years	May 1969-May 1972	David Eckstein Mercer
4th District	3 years	May 1969-May 1972	*Frank J. Hughes Camden

*Ineligible for re-election, having served 3 full terms.

Judicial Councilors:			
1st District	3 years	May 1969-May 1972	Thomas S. P. Fitch Union
4th District	3 years	May 1969-May 1972	I. Edward Ornaf Camden
AMA Delegates	2 years	Jan. 1970-Dec. 1971	Joseph P. Donnelly Hudson
	2 years	Jan. 1970-Dec. 1971	Jesse McCall Sussex
	2 years	Jan. 1970-Dec. 1971	Isaac N. Patterson Gloucester
AMA Alternate Delegates	2 years	Jan. 1970-Dec. 1971	Joseph R. Jehl Passaic
	2 years	Jan. 1970-Dec. 1971	Robert E. Verdon Bergen
	2 years	Jan. 1970-Dec. 1971	Louis S. Wegryn Union
Delegates and Alternate Delegates to Other States:			
New York:			
Delegate	1 year	1970 Annual Meeting	Albert F. Moriconi Mercer
Alternate	1 year	1970 Annual Meeting	Josiah C. McCracken, Jr. Atlantic
Connecticut:			
Delegate	1 year	1970 Annual Meeting	Lloyd A. Hamilton Hunterdon
Alternate	1 year	1970 Annual Meeting	Frank W. Konzelmann Atlantic
Administrative Councils:			
Legislation:			
5th District	3 years	May 1969-May 1972	John S. Madara Salem
6th Member	3 years	May 1969-May 1972	Winton H. Johnson Bergen
Medical Services:			
5th District	3 years	May 1969-May 1972	**Charles B. Norton, Jr. Salem
6th Member	3 years	May 1969-May 1972	I. Edward Ornaf Camden
Mental Health:			
3rd District	3 years	May 1969-May 1972	Robert S. Garber Somerset
6th Member	3 years	May 1969-May 1972	Evelyn P. Ivey Morris
Public Health:			
5th District	3 years	May 1969-May 1972	Robert G. Salasin Cape May
6th Member	3 years	May 1969-May 1972	**John P. Coughlin Hudson
Public Relations:			
2nd District	3 years	May 1969-May 1972	Francis I. Tomlins Bergen
5th District	3 years	May 1969-May 1972	Josiah C. McCracken, Jr. Atlantic
Standing Committees:			
Annual Meeting	3 years	May 1969-May 1972	Robert E. Verdon Bergen
Finance and Budget	3 years	May 1969-May 1972	Theodore K. Graham Passaic . . . (deceased)
Medical Defense and Insurance	3 years	May 1969-May 1972	**Ernest C. Hillman, Jr. Essex
Medical Education	3 years	May 1969-May 1972	**Louis F. Albright Monmouth
Publication	3 years	May 1969-May 1972	George B. Sharbaugh Mercer
Woman's Auxiliary Advisory	3 years	May 1969-May 1972	**George O. Rowohlt Bergen

**Ineligible for re-election, having served 3 consecutive terms.

1969 Annual Meeting

SPEAKERS

Saturday through Tuesday
May 17 to 20, 1969

Chalfonte-Haddon Hall
Atlantic City

Behrle, Franklin C., M.D., Jersey City
Boonin, Nathaniel N., M.D., Trenton
Brancato, Russell W., M.D., Newark
Breen, James L., M.D., Newark
Brodkin, Roger H., M.D., Irvington
Bruton, William C., M.D., Summit

Carroll, Robert, M.D., Philadelphia
Christian, Charles L., M.D., New York
Conroy, William C., M.D., Montclair

Fenner, Edmund M., Manville
Franklin, Edward C., M.D., New York
Frazell, Edgar L., M.D., New York

Goger, Pauline R., M.D., Flemington
Goldstein, Daniel L., M.D., Hackensack
Groisser, Victor W., M.D., Montclair

Harley, Robinson D., M.D., Atlantic City
Hughes, Governor Richard J., Trenton

Inzinna, Joseph F., M.D., Jersey City

Knauer, Warren H., M.D., Elizabeth
Koeck, George P., M.D., Newark
Kremer, Malvina W., M.D., New York

Levine, Bernard B., M.D., New York
Levinson, Gilbert E., M.D., Jersey City

Mancusi-Ungaro, Alvin P., M.D., Montclair
Manley, Donelson R., M.D., Philadelphia
Martin, Professor Walter R., Wayne
Mayer, D. McCullagh, M.D., Rutherford
McCorkle, Commissioner Lloyd W., Trenton
Moolten, Sylvan E., M.D., New Brunswick
Morales, Pablo A., M.D., New York

Noguera, Julio T., M.D., Neptune City

O'Regan, Daniel J., M.D., Jersey City

Palmer, Eddy D., M.D., Montclair
Parks, Marshall M., M.D., Washington, D. C.
Parmet, Morris, M.D., Princeton
Parsonnet, Victor, M.D., Millburn
Peer, Lyndon A., M.D., East Orange
Portfolio, A. G., M.D., Ridgewood

Rackow, Herbert, M.D., New York
Reilly, Christopher T., M.D., Ridgewood
Riva, Humbert L., M.D., Jersey City
Roschelle, Ira A., M.D., Passaic
Ryan, Walter M., Jr., M.D., Neptune Ctiy

Salvati, Eugene P., M.D., Plainfield
Schlosser, Woodrow D., M.D., Philadelphia
Schnee, Isadore M., M.D., Paterson
Selikoff, Irving J., M.D., Paterson
Shapiro, Lewis, M.D., New Hyde Park, N. Y.
Smith, Richard T., M.D., Philadelphia
Soricelli, Richard R., M.D., Philadelphia
Spindell, Lloyd N., M.D., Newark
Stern, Richard U., M.D., Newark

Timmes, Joseph J., M.D., Jersey City
Tollefsen, H. Randall, M.D., New York

Van Avery, Jasper L., M.D., New Brunswick

Weiss, Stuart A., M.D., Long Branch
Wertz, Frederick J., M.D., Fort Lee
Whims, Clarence B., M.D., Ventnor City
Wilson, E. Robert, M.D., Paterson
Winter, Arthur, M.D., East Orange
Wuester, William O., M.D., Elizabeth

Yoslow, Wilfred, M.D., New York

1969 Annual Meeting

SCIENTIFIC SECTION OFFICERS

Saturday through Tuesday
May 17 to 20, 1969

Chalfonte-Haddon Hall
Atlantic City

Allergy
CHAIRMAN—Edward Pickert, M.D., Irvington
SECRETARY—Allan G. Posta, M.D., Trenton

Anesthesiology
CHAIRMAN—Thomas C. Wickenden, M.D., Short Hills
SECRETARY—Arganey L. Lucas, Jr., M.D., Dover

Cardiovascular Diseases
CHAIRMAN—William M. Burke, M.D., Millburn
SECRETARY—Allen B. Weisse, M.D., Jersey City

Chest Diseases
CHAIRMAN—James R. Johnson, M.D., Jersey City
SECRETARY—Walter Nudelman, M.D., Maplewood

Clinical Pathology
CHAIRMAN—Vincent H. Gillson, M.D., Westwood
SECRETARY—Philip J. E. Quigley, M.D., Elizabeth

Dermatology
CHAIRMAN—Irwin L. Maskin, M.D., Fair Lawn
SECRETARY—Martin H. Wortzel, M.D., Millburn

Gastroenterology and Proctology
CHAIRMAN—Louis A. Brodkin, M.D., Irvington
SECRETARY—Benjamin H. Schatman, M.D., East Orange

General Practice
CHAIRMAN—William L. Sprout, M.D., Salem
SECRETARY—Nelson C. Walker, M.D., Hackensack

Medicine
CHAIRMAN—Howard A. Levy, M.D., Collingswood
SECRETARY—Bascom S. Waugh, M.D., Camden

Metabolism
CHAIRMAN—Pauline R. Goger, M.D., Flemington
SECRETARY—Lewis Schwartz, M.D., Jersey City

Obstetrics and Gynecology
CHAIRMAN—Herik R. Caterini, M.D., Newark
SECRETARY—Samuel J. Fortunato, M.D., Short Hills

Ophthalmology
CHAIRMAN—Samuel B. Pole, M.D., Bridgeton
SECRETARY—I. Allen Chirls, M.D., East Orange

Orthopedic Surgery
CHAIRMAN—John C. Roy, M.D., Morristown
SECRETARY—Donald J. Holtzman, M.D., Elizabeth

Otolaryngology
CHAIRMAN—F. Robert Haase, M.D., Neptune City
SECRETARY—Harvey P. Yeager, M.D., Millburn

Pediatrics
CHAIRMAN—Alvin R. Mintz, M.D., Morristown
SECRETARY—C. Prentiss Ward, M.D., Belleville

Plastic and Reconstructive Surgery
CHAIRMAN—Vincent J. Bagli, M.D., Ridgewood
SECRETARY—Stephen R. Lo Verme, M.D., East Orange

Psychiatry and Neurology
CHAIRMAN—Avrohn Jacobson, M.D., Asbury Park
SECRETARY—Mary Ann Bartusis, M.D., Trenton

Radiology
CHAIRMAN—Richard G. Kirchner, M.D., New Brunswick
SECRETARY—Leopold S. Kaplan, M.D., Highland Park

Rheumatism
CHAIRMAN—James W. Robinson, M.D., Summit
SECRETARY—Lonnie B. Hanauer, M.D., Millburn

Surgery
CHAIRMAN—Warren H. Knauer, M.D., Hillside
SECRETARY—James J. Chandler, M.D., Princeton

Urology
CHAIRMAN—Bernard D. Pinck, M.D., Passaic
SECRETARY—Frederick Lerman, M.D., Elizabeth

1969 *Annual Meeting*

SCIENTIFIC PROGRAM

Monday, May 19
Tuesday, May 20

Scientific
Section Sessions

Scientific Section Sessions

Monday Morning, May 19

Joint Session

Sections on:

Allergy
Metabolism

Presiding
Pauline R. Goger, M.D., Chairman
Section on Metabolism

9:30 a.m. / Election of Officers for 1970

9:45 a.m. / Symposium on Advances in Immunology
Moderator: PAULINE R. GOGER, M.D., Assistant Director, Department of Internal Medicine, Hunterdon Medical Center, Flemington; and Clinical Instructor in Medicine, New York University School of Medicine, New York

Structure and Function of Immunoglobulins
EDWARD C. FRANKLIN, M.D., Professor of Medicine and Chairman, Rheumatic Diseases Study Group, New York University School of Medicine, New York

Summary not received

Clinical and Immunological Mechanisms of Drug Allergies
BERNARD B. LEVINE, M.D., Associate Professor of Medicine, New York University School of Medicine, New York

Summary not received

Clinical Immunology, Orderly and Disorderly
JASPER L. VAN AVERY, JR., M.D., Attending Physician, Middlesex General Hospital, New Brunswick

Immunity is a highly specific complex defense of the body against progressive damage by chemical, viral, bacterial, and other invaders. Immunity is the result of an orderly response of mononuclear cells, immune globulins, and complement to antigenic stimulation by the invader. Current understanding of the roles of these components is here reviewed, in relation to clinical manifestations of disorders of their function as a consequence of congenital defects, disease of the responsible tissue, or deliberate manipulation during therapy. Illustrative case reports are presented.

11:15 a.m. / Panel Discussion

11:45 a.m. / Visit to Exhibits

12:30 p.m. / Luncheon—New Jersey Allergy Society
Speaker: MURRAY DWORETZKY, M.D., Allergy Clinic, New York Hospital-Columbia Medical Center, New York
Reservations: ALAN G. POSTA, M.D., 2566 Nottingham Way, Trenton

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Joint Session

Sections on:

Chest Diseases
Clinical Pathology

Presiding

J. Randolph Johnson, M.D., Chairman
Section on Chest Diseases

9:30 a.m. / Election of Officers for 1970

9:45 a.m. / Symposium on the Industrial Pneumoconioses in New Jersey

General Considerations
IRVING J. SELIKOFF, M.D., Paterson; Professor of Community Medicine and Director of Environmental Sciences Laboratory, Mount Sinai School of Medicine, New York

Summary not received

Pathologic Manifestations
SYLVAN E. MOOLTEN, M.D., Director of Laboratories, Middlesex General Hospital; and Clinical Professor of Pathology, Rutgers Medical School, New Brunswick

The pathogenicity of inhaled particles depends on both dosage and host response. Reactions to coal dust vary with the nature and severity of coexisting chronic bronchitis, tuberculosis, or rheumatoid disease. Silicosis also embodies an "auto-immune" reaction to phagocytes altered by silica. The phenomenal adsorbing activity of asbestos fibers trapped in the finer air passages favors accumulation of inhaled potential carcinogens which may explain the relatively high incidence of associated cancer of the lung, mesothelioma of the pleura or peritoneum and cancer of the gastrointestinal tract and other systems.

Radiologic Patterns
JOSEPH F. INZINNA, M.D., Director of Radiology, Jersey City Medical Center; and Instructor in Clinical Radiology, New Jersey College of Medicine and Dentistry

Not until the discovery of x-rays were the pulmonary manifestations of the pneumoconioses adequately evaluated *in vivo*. Indeed, many clinical descriptions of it are truly derived from radiographic observations. Such a classification of the pneumoconioses is offered along with roentgen descriptions of other entities and their diverse phases of evolution.

In New Jersey, an average of $1,000,000 in compensation has been paid in each of the last 3 years for this occupational disease. It makes up 25 to 30 per cent of all paid compensated cases in our State. In this, it is preceded only by chronic bronchitis, dermatitis and deafness, according to the New Jersey Department of Labor's Annual 1967 Report.

Prevention and Control
EDMUND M. FENNER, Director, Environmental Control, Johns-Manville Products Corporation, Manville

Prevention of industrial pneumoconioses depends largely on control of respirable dusts. For asbestos dusts, at least, this is confirmed in U. S. and British epidemiologic studies. Control technology is already available and being widely applied throughout the industry. In Johns-Manville, unified industrial hygiene standards are administered through a central Department of Environmental Control. As part of the Company's overall control effort, Johns-Manville is co-sponsoring a research program to develop improved methods for protecting insulation and other construction workers from on the job exposure to dust and fumes. Prevention and control need solid support in corporate policy. Johns-Manville is on record as being pledged "to develop ways of assuring maximum possible protection from occupational hazards" for employees in all its installations and among fabricators and applicators.

11:10 a.m. / Panel Discussion

11:45 a.m. / Visit to Exhibits

12:30 p.m. / Luncheon Meeting, New Jersey Chapter, American College of Chest Physicians
Reservations: RAYMOND E. MILLER, M.D., 192 West State Street, Trenton

Joint Session

Sections on:

Obstetrics and Gynecology Radiology

Presiding

Richard G. Krichner, M.D., Chairman
Section on Radiology

9:30 a.m. / Election of Officers for 1970

9:45 a.m. / Symposium on Carcinoma of the Uterus and Cervix

Radiation Therapy of Carcinoma of the Body of the Uterus and Cervix
GEORGE P. KOECK, M.D., Director, Radiation Therapy, Presbyterian Hospital, Newark

A method is here described for treating carcinoma of the cervix using only external radiation therapy. Radium is not employed in any form. The uterus, parametria and pelvic lymph nodes are all treated *en bloc* through a 14 by 14 centimeter field by rotating a cobalt-60 machine through 360 degrees about the pelvis. The method is simple and easily reproduced. It is available to patients of all sizes, ages, and stages of disease. Hospitalization is not necessary for therapy. Results compare favorably with the best obtained in large cancer centers with combinations of other methods.

A Radiologist's Approach to Radiation Therapy of Carcinoma of the Uterus and Cervix
STUART A. WEISS, M.D., Director, Department of Therapeutic Radiology, Monmouth Medical Center, Long Branch

This presentation will be built around slides shown by Dr. Weiss to light up the problem of radiation therapy to uterine tissues.

Diagnosis and Treatment of Early Cervical Cancer and Its Precursors
HUMBERT L. RIVA, M.D., Professor, Department of Gynecology and Obstetrics, New Jersey College of Medicine and Dentistry

Summary not received

Individualized Therapy of Cancer of the Cervix
JAMES L. BREEN, M.D., Director, Department of Gynecology and Obstetrics, Martland Hospital Unit, Newark; and Associate Professor, Department of Gynecology and Obstetrics, New Jersey College of Medicine and Dentistry

Here offered is a review of individualized modalities of therapy as related to the types and stages of neoplasia of the cervix. The authors describe the therapy of 500 patients with carcinoma of the cervix. The philosophy of management is discussed.

11:10 a.m. / Panel Discussion

11:45 a.m. / Visit to Exhibits

Section on

Orthopedic Surgery

Cosponsored by the New Jersey Orthopedic Society

Presiding

Robert C. Green, M.D.

9:30 a.m. / Election of Officers for 1970

9:45 a.m. / Osteomyelitis of the Spine in Children
E. ROBERT WILSON, M.D., Adjunct Attending in Orthopedic Surgery, St. Joseph's Hospital, Paterson

Two cases of osteomyelitis of the spine in young children are presented. The difficulty of making the diagnosis is emphasized. Causes of the disease are reviewed. A brief summary of the literature will be given.

10:15 a.m. / Synovectomy of the Elbow in Rheumatoid Arthritis
IRA A. ROSCHELLE, M.D., Associate Orthopedic Surgeon, Beth Israel Hospital, Passaic

A small series of patients with severe ankylosis of the elbow joints in chronic rheumatoid arthritis have undergone synovectomy and debridement of the elbow, and have regained motion and relief of pain.

Coffee Break

10:45 a.m. / Lisfranc Dislocations

DANIEL J. O'REGAN, M.D., Attending in Orthopedic Surgery, St. Francis Hospital, Jersey City

Summary not received

11:15 a.m. / Compression Plate Fixation in High Femoral Osteotomy
WILFRED YOSLOW, M.D., Associate Attending in Orthopedic Surgery, Bellevue Hospital, New York

Twenty-seven patients, ranging in age from 7 to 68, had intertrochanteric femoral osteotomies performed for varying pathologic states. These were fixed internally with the AO compression blade plate. There was rapid cessation of post-operative pain and accelerated bony union with minimal external callus formation in all the patients. Solid bony union was usually obtained in eight weeks with full weight-bearing permissible in ten. No wound infections occurred. The end results using the AO technics were impressively satisfactory.

Discussion

11:45 a.m. / Visit to Exhibits

12:30 p.m. / Luncheon Meeting
New Jersey Orthopedic Society
Reservations: ROBERT G. GREENE, M.D., 66 South Fullerton Avenue, Montclair

Section on:

Otolaryngology

Presiding

F. Robert Haase, M.D., Chairman

9:30 a.m. / Election of Officers for 1970

9:45 a.m. / Symposium on Tympanoplasty
Results at one and two years by types in the case of each speaker
WOODROW D. SCHLOSSER, M.D., Chief of ENT, Graduate Hospital, University of Pennsylvania; and Associate Professor of Otolaryngology, University of Pennsylvania School of Medicine, Philadelphia

The principles and aims of a tympanoplasty are reviewed. Briefly, aims include the mandatory removal or eradication of the disease, and then the improvement or reconstruction of the sound conductive mechanism. Also, here discussed will be the classification of types of surgery and the definition of the type of tympanoplasty proposed by the Committee on Conservation of Hearing of the American Academy of Ophthalmology and Otolaryngology. Dr. Schlosser will offer statistical review of 131 cases followed for a two year period. The improvement will be discussed in several categories, and for each type of tympanoplastic reconstruction.

ISADORE M. SCHNEE, M.D., Chairman, Department of Otolaryngology, Nathan and Miriam Barnert Memorial Hospital Center, Paterson; and Attending Surgeon in Otology, Manhattan Eye, Ear and Throat Hospital, New York

Results in tympanoplasty vary with the type of reconstruction. First, disease in the middle ear and mastoid is eliminated. In Type I tympanoplasty, the drum is repaired with vein, fascia, or skin. In Type II, additionally, the incus defect is repaired by repositioning or substituting wire or cartilage. In Type III the drum is lowered to make contact with the stapes. Here, malleus and incus are absent. Favorable results are obtained in 90 per cent Type I; 80 per cent Type II; and 50 per cent Type III. A 25 per cent revision is required within two years. An intact canal wall mastoidectomy obviates the necessity to resort to Type III, thus improving results.

JULIO T. NOGUERA, M.D., Chief, Department of Otolaryngology, Jersey Shore Medical Center, Neptune

The author here reviews results of a series of tympanoplasties using the commonly accepted technics of tympanic membrane grafting and ossicular repositioning. Results of the classical tympanoplasty then are compared with the results of a preliminary report on the use of a Silastic® prosthesis as a substitute for the ossicular chain in radical mastoidectomies and in other cases with severe ossicular defects. A short history of the development of this prosthesis will be presented with the modifications and the reasons for the modifications as experience was gained with its use.

10:50 a.m. / Panel Discussion

11:45 a.m. / Visit to Exhibits

12:30 p.m. / **Luncheon Meeting**
New Jersey Chapter, American Academy of Pediatrics Reservations: ALVIN R. MINTZ, M.D., 59 Woodland Avenue, West Orange

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Anesthesia Problems Associated with Obstructive Uropathy

HERBERT RACKOW, M.D., Associate Attending Anesthesiologist, Columbia-Presbyterian Medical Center; and Associate Professor of Anesthesiology, Columbia University College of Physicians and Surgeons, New York

Summary not received

Monday Afternoon, May 19

Joint Session

Sections on:

Anesthesiology
Pediatrics
Urology

Presiding

Alvin R. Mintz, M.D., Chairman
Section on Pediatrics

2:00 p.m. / **Election of Officers for 1970**

2:15 p.m. / **Symposium on Obstructive Uropathy in Childhood**

The Role of the Pediatrician in Detecting Obstructive Uropathy
FRANKLIN C. BEHRLE, M.D., Professor and Chairman, Department of Pediatrics, New Jersey College of Medicine and Dentistry; and Pediatrician-in-Chief, New Jersey College of Medicine Hospitals, Newark

The speaker will discuss the symptoms and signs which should call attention to the possibility of obstructive uropathy in infants and small children. It is imperative to be acutely aware of this entity, since early diagnosis usually permits surgical correction and a favorable outlook. Delay in recognition results in irreversible kidney damage with early death from renal failure, despite corrective measures.

Obstructive Uropathy in the Young
PABLO A. MORALES, M.D., Associate Professor of Urology, New York University School of Medicine, New York, N. Y.

In infants and children, over 90 per cent of persistent or recurring urinary tract infections are obstructive in nature. Nearly half of the recognizable obstructions among children are at the bladder neck, and a smaller number are at the ureteropelvic junction. The role of radiology, urological instrumentation, and physiologic testing (pressure flow studies) in the diagnosis of obstructive uropathy and the indications, objectives, and technics of management will be discussed.

3:25 p.m. / **Panel Discussion**

4:15 p.m. / **Visit to Exhibits**

Section on:

Ophthalmology

Presiding

Samuel B. Pole, M.D., Chairman

2:00 p.m. / **Election of Officers for 1970**

2:15 p.m. / **Symposium on Cryo-Surgery and Extra Ocular Muscle Dyscrasia**

Micro-Surgical Technics in Ocular Surgery

RICHARD U. STERN, M.D., Associate Attending in Ophthalmology, Newark Eye and Ear Infirmary; and Clinical Assistant Professor of Ophthalmology, New Jersey College of Medicine and Dentistry

Suture of corneal wounds in cataract surgery and corneal transplant surgery require good approximation of tissue and a water-tight seal. The mechanics of wound closure and wound stress in various suture technics will be described and demonstrated in detail, with a hope of eventually devising an ideal wound closure for cataract and transplant surgery.

Surgery of Esotropia
DONELSON R. MANLEY, M.D., Assistant Professor of Ophthalmology, Temple University School of Medicine; and Pediatric Ophthalmologist, St. Christopher's Hospital for Children, Philadelphia

Summary not received

Surgery of Exotropia
A. G. PORTFOLIO, M.D., Attending in Ophthalmology, The Valley Hospital, Ridgewood; and Associate Clinical Professor of Ophthalmology, New York University School of Medicine, New York

Exotropia, which includes intermittent exotropia, is essentially a surgical problem. The procedure of

choice is bilateral recession of lateral recti or recession of lateral rectus with resection of the medial rectus. Post-operative exotropia should be re-evaluated as a new case. Over-corrections producing esotropia are treated conservatively because of high incidence of spontaneous resolution. Exotropia with AV pattern should be operated on, according to absence or presence of oblique dysfunction. Without oblique dysfunction the horizontal recti should be supra or infra placed along with appropriate recession or resection of these muscles. With oblique dysfunction the inferior obliques, if overacting, should be disinserted or the superior obliques, if overacting, should be tenectomized along with appropriate horizontal rectus surgery.

Complications of Muscle Surgery
MARSHALL M. PARKS, M.D., Clinical Professor of Ophthalmology, George Washington University; and Senior Attending in Ophthalmology, Washington Hospital Center, Washington, D. C.

Summary not received

3:45 p.m. / Surgical Management of Vertical Muscle Anomalies Including The A-V Syndrome

ROBISON D. HARLEY, M.D., Atlantic City; Professor of Ophthalmology, Temple University School of Medicine, and Attending Surgeon, Wills Eye Hospital and Research Institute, Philadelphia

Anomalies of the vertically acting muscles occur in at least 40 per cent of all heterotropic cases, either in combination with horizontal deviations or as vertical deviations above. The superior oblique muscle was the most commonly involved individual vertical muscle in a series of over two hundred cases of heterotropia. It was diagnosed as the primary paretic muscle in fifteen per cent of the cerebral palsy cases where strabismus was present. Vertical muscle imbalances are most commonly recognized with horizontal strabismus but sometimes become quite apparent following surgery on the horizontal muscles. Diagnostic technics and surgical management will be discussed.

4:15 p.m. / Visit to Exhibits

Visit The Exhibits

Informational

Scientific

Technical

May 17-20 Haddon Hall

Section on:

Psychiatry and Neurology

Presiding

Avrohn Jacobson, M.D., Chairman

2:00 p.m. / Election of Officers for 1970

2:15 p.m. / Symposium on the Identity Crises of the Advantaged and Disadvantaged Adolescent and Their Problems with Society Today

The Disadvantaged Adolescent: A Psychodynamic Evaluation
FREDERICK J. WERTZ, M.D., Chief, Child and Adolescent Outpatient Clinic, Neuropsychiatric Service, Englewood Hospital

The psychiatric problems of the disadvantaged adolescent are viewed from three spheres of influence: social, familial, and intrapsychic. The author considers the effect of ghetto living, chronic unemployment and welfare subsistence on the mental health of the adolescent's family as one of the primary factors in adolescent psychopathology.

Family interpersonal relationships, particularly the roles of the parents in relation to each other and the kinds of adult models they present for the adolescent to emulate, are evaluated in terms of their influence on the maturing adolescent. Finally, intrapsychic factors within the adolescent himself, such as his sexual identity, his family identity, and his social identity, are highlighted as contributors toward the personality formation of the adolescent years.

Identity Crises of the Advantaged Child
MORRIS PARMET, M.D., Consultant in Adolescent Psychiatry, The Carrier Clinic, Belle Mead

Identity crisis does not describe all the problems of the children of affluent parents who come to the author's attention. Some, after all, are the same problems of growth which occur in any milieu and which in adolescence take the form of separation and differentiation from parents and parent surrogates.

Dr. Parmet's purpose is to describe particular problems which relate in large share to society's impact and which are manifest in variations on the theme of drugs, dress, demonstrations, or "dropping out." What affluent youth is trying to tell us in the style and content of their problems, is the author's task in this presentation.

Adolescents and Their Problems with Society
Malvina W. Kremer, M.D., Assistant Clinical Professor of Psychiatry, New York University School of Medicine; and Chief, Adolescent Clinic, Metropolitan Hospital, New York

The developmental tasks of childhood are largely intra-organismic and maturational. By contrast, the tasks of adolescence are oriented toward the external world. They include the definition of role in life, the assumption of independence and adult re-

sponsibilities, and the establishment of a definitive sexual role. Usually, at this point each individual acquires the framework of institutionalized values and standards that enables him to live within his society. There have always been deviants and rebels, some constructive and others merely rebellious. The present era finds large numbers of adolescents rejecting the basic framework of values and institutions of our society. This poses an unprecedented set of problems on all levels. This paper will consider some of the clinical problems posed by these phenomena.

3:30 p.m. / Panel Discussion

Discussant:

NATHANIEL N. BOONIN, M.D., Director, Child Guidance Center of Mercer County, Trenton and Princeton; and Clinical Assistant Professor of Psychiatry, New Jersey College of Medicine and Dentistry

4:15 p.m. / Visit to Exhibits

Section on:

Rheumatism

Presiding

James W. Robinson, M.D., Chairman

2:00 p.m. / Election of Officers for 1970

2:15 p.m. / Some Aspects of Immunology for the Clinician
CHARLES L. CHRISTIAN, M.D., Associate Professor of Medicine, Columbia University College of Physicians and Surgeons, New York

Although the definitions of several rheumatic disease syndromes are based primarily on clinical criteria, laboratory information is of value in differentiating syndromes with similar expressions. Certain types of laboratory data have prognostic significance. These do point to mechanisms involved in the pathogenesis of diseases such as rheumatoid arthritis, rheumatic fever, systemic lupus erythematosus and gout. The role of commonly used laboratory methods in rheumatic disease problems will be reviewed.

2:40 p.m. / How to Get the Most from Aspirin
CLARENCE B. WHIMS, M.D., Ventnor; Consultant in Rheumatology, Atlantic City Hospital

During man's search for a cheap and plentiful quinine substitute, aspirin was found and its analgesic effect noted. Its trial as an antirheumatic agent, however, was delayed until 1899. Seventy years of use has confirmed the fact that it combines well with other compounds, that it is relatively free of major undesirable effects, that it is inexpensive, that it creates a sense of well being, that it often improves appetite and that it seems to limit or reduce tissue inflammation.

Orally ingested, unbuffered aspirin is rapidly absorbed, readily and widely distributed but slowly eliminated in the urine. Recommended dosage is 0.6 to 1.2 grams every four hours around the clock.

3:05 p.m. / Individualized Dosage of Gold in the Treatment of Rheumatoid Arthritis
RICHARD T. SMITH, M.D., Director, Department of Rheumatology, Benjamin Franklin Clinic of Pennsylvania Hospital, Philadelphia

The unfortunate attitude of physician and layman, "that there is no specific therapy for rheumatoid arthritis" is based on inexpert use and uncritical evaluation of soluble gold. Despite 35 years of usage, few practitioners seem to have discovered the specificity of chrysotherapy for rheumatoid arthritis. Instead of administering gold according to antiquated formulas (which can induce remissions in 30 to 65 per cent of patients) individualizing the dosage can increase the remission rate to 85 per cent or more without producing any greater risk of toxic reactions. Individualized chrysotherapy should be the backbone of the treatment program for rheumatoid arthritis.

3:30 p.m. / Surgery of the Rheumatoid Hand
WILLIAM J. BRUTON, M.D., Orthopedic Surgeon, Overlook Hospital, Summit

In the past ten years, the emphasis in the surgical treatment of the rheumatoid hand has shifted from late attempts to restore some degree of function to a totally disabled hand to earlier procedures designed to preserve function before major disability occurs. Procedures available for treatment of the rheumatoid wrist, metacarpal phalangeal joints and digits will be reviewed and a request made for earlier consideration of surgery in appropriate patients.

3:50 p.m. / Discussion

4:15 p.m. / Visit to Exhibits

Section on:

Surgery

Presiding

Warren H. Knauer, M.D., Chairman

2:00 p.m. / Election of Officers for 1970

2:15 p.m. / Tumors of the Major Salivary Glands
EDGAR L. FRAZELL, M.D., Chief, Head and Neck Service, Memorial Hospital, New York

Salivary gland tumors are uncommon. The majority are benign and all of these are curable by well-

planned surgery. Except for the low grade mucoepidermoid tumors the cure rate for malignant growths has been unsatisfactory. Failure to control disease at the primary site with ultimate regional and distant spread accounts for the poor results achieved. A well-conceived treatment plan should improve future results.

2:40 p.m. / Cancer of the Tongue
WILLIAM O. WUESTER, M.D., Director, Wuester Tumor Clinic, Elizabeth; and Assistant Professor of Clinical Surgery, New Jersey College of Medicine and Dentistry

This presentation is entirely from 35 millimeter Kodachromes illustrating the various stages of the disease from pre-cancerous lesions to advanced cancer. With each stage, a short discussion is offered to illustrate the special problems to be surmounted.

3:00 p.m. / Papillary Carcinoma of the Thyroid
H. RANDALL TOLLEFSEN, M.D., Associate Attending Surgeon, Head and Neck Service, Memorial Hospital; and Clinical Associate Professor of Surgery, Cornell University Medical College, New York

From 1930 through June 1957, 966 patients with thyroid cancer were seen by members of the Head and Neck Service at Memorial Hospital, New York City. Of these, 51 per cent had papillary thyroid carcinoma. Of the 496, 282 patients had their *initial* surgical management at this hospital. The treatment of this group of primary papillary thyroid cancers will be discussed.

3:25 p.m. / Cervical Metastases of Head and Neck Cancer
WARREN H. KNAUER, M.D., Associate, Wuester Tumor Clinic, Elizabeth; and Assistant Professor of Clinical Surgery, New Jersey College of Medicine and Dentistry

With the availability of curative procedures for cancers of the head and neck, the need for proper diagnosis becomes imperative. We must remember the frequency with which cervical metastases may appear as the first and only symptom in carcinoma of the mouth, pharynx, and larynx. Certainly, there can be no possibility of cure until the primary lesion is found and treated adequately.

It should no longer be common practice to carry out excisional biopsies of masses in the neck before complete examination of the head and neck area has been completed. Aspiration biopsy is a vital tool in this investigative process.

The immediate removal of a lymph node in the neck for diagnosis is never in the best interest of the patient and should be used only as a diagnostic last resort.

3:45 p.m. / Question and Answer Period

4:15 p.m. / Visit to Exhibits

Tuesday Morning, May 20

Section on:

Cardiovascular Diseases

Presiding

William M. Burke, M.D., Chairman

9:30 a.m. / Election of Officers for 1970

9:45 a.m. / Symposium on Medical-Surgical Evaluation of Cardiovascular Problems
Panelists:
GILBERT E. LEVINSON, M.D., Associate Director, Thomas J. White Cardiopulmonary Institute, Berthold S. Pollak Hospital for Chest Diseases, Jersey City; and Professor of Medicine, New Jersey College of Medicine and Dentistry

Instead of offering a formal didactic paper, Dr. Levinson will invite participation in a colloquium on the management of diverse cardiologic problems.

JOSEPH J. TIMMES, M.D., Chief of Thoracic Surgery, Berthold S. Pollak Hospital for Chest Diseases, Jersey City; and Professor of Surgery, New Jersey College of Medicine and Dentistry

This will be a panel discussion without a script. Cases will be presented. These will be cases of clinical interest, previously unknown to the members of the panel.

VICTOR PARSONNET, M.D., Millburn; Director of Surgery, Newark Beth Israel Medical Center; and Clinical Associate Professor of Surgery, New Jersey College of Medicine and Dentistry

Summary not received

RUSSELL W. BRANCATO, M.D., Director, Cardiopulmonary Laboratory, St. Michael Hospital, Newark; and Clinical Assistant Professor of Medicine, New Jersey College of Medicine and Dentistry

Summary not received

11:10 a.m. / Panel Discussion

11:45 a.m. / Visit to Exhibits

12:00 noon / Luncheon
Section on Cardiovascular Diseases
Reservations: WILLIAM M. BURKE, M.D., 276 Essex Avenue, Millburn

Joint Session

Sections on:

Gastroenterology and Proctology General Practice

Presiding

Louis A. Brodkin, M.D., Chairman
Section on Gastroenterology and Proctology

9:30 a.m. / Election of Officers for 1970

9:45 a.m. / Gastrointestinal Symposium—The Beginning and End

Inflammatory Diseases of the Esophagus

EDDY D. PALMER, M.D., Clinical Professor of Medicine, New Jersey College of Medicine and Dentistry; and Director, Gastroenterology, U. S. Veterans Administration Hospital, East Orange

Many specific inflammatory diseases are capable of injuring the esophagus. By far the most common form of esophagitis, however, is a diffuse subacute or chronic idiopathic, noninfectious intramural inflammation. Although this form has in the past been referred to as "reflux," "septic" or "regurgitant" esophagitis (to suggest an etiologic role for the stomach's normal secretions), the histopathologic facts show that surface epithelial changes follow establishment of a diffuse inflammatory reaction in the submucosa and muscularis propria. The disease does not begin on the mucosal surface and work its way downward. There are two very serious complications, hemorrhage from secondary surface erosions and stricture subsequent to deep fibroplasia.

Granulomatous Disease of the Ileo-Colonic Segment
Panelists:

VICTOR W. GROISSER, M.D., Clinical Associate Professor of Medicine, New Jersey College of Medicine and Dentistry; and Director, Division of Gastroenterology, Mountainside Hospital, Montclair

During recent years, increasing distinction has been made between granulomatous colitis and ulcerative colitis. To be sure, there is considerable overlap of clinical features. But, diagnostic differentiation between these diseases can often be made on the basis of radiographic and pathologic features.

In contrast to the mucosal involvement in ulcerative colitis, granulomatous colitis is a trans-mural process, often found in association with granulomatous disease of the small bowel. The changes are often segmental and the rectum is usually spared. Toxic megacolon and the occurrence of colonic carcinoma is much more frequent in ulcerative colitis than in granulomatous colitis.

Medical therapy of both diseases is similar. Following surgery, granulomatous ileo-colitis may recur.

LLOYD N. SPINDELL, M.D., Director of Radiology, Newark Beth Israel Medical Center

Roentgen changes in granulomatous ileitis are sufficiently characteristic for appropriate diagnosis. However, when the same pathologic process involves the large bowel independently (granulomatous colitis or Crohn's disease) diagnosis may be difficult because of confusion with similar radiographic appearances in ulcerative colitis. If an intrinsic inflammatory process can be established in both the ileum and large intestine, the radiographic identification of granulomatous features in the ileum is strong evidence for an identical etiology in the colon. In the absence of a definite diagnosis of regional ileitis, attention to the patterns of distribution of the disease in the large bowel and observation of certain gross radiographic findings can be helpful in arriving at a proper diagnosis.

EUGENE P. SALVATI, M.D., Associate Attending in Surgery, Muhlenberg Hospital, Plainfield

Surgery for granulomatous disease of the ileum and colon should be limited to treating the complications of this disease, i.e. obstruction and fistulization. Good results can be expected in patients with obstruction, if the disease is limited to the ileum. Anal fistula is quite common and frequently precedes the diagnosis of ileitis. Patients with ulcerative colitis who develop regional enteritis subsequent to the colectomy and ileostomy fare poorly regardless of management whether medical or surgical. Granulomatous ileocolitis is more resistant to medical management than ulcerative colitis. Of thirteen patients surgically treated for granulomatous ileocolitis, further surgery was necessary in four. Only one patient of nine, however, required further surgery in those patients operated on for obstructive ileitis; the other three recurrences developed in mixed forms of the disease.

The program is acceptable for two prescribed hours by the American Academy of General Practice.

11:10 a.m. / Panel Discussion

11:45 a.m. / Visit to Exhibits

"The Concept"

(Live Theatre)

see page 153

Saturday, May 17 9:00 p.m.

Viking Room Haddon Hall

Tuesday Afternoon, May 20

Joint Session

Sections on:

Dermatology
Medicine

Presiding

Irwin L. Maskin, M.D., and Howard A. Levy, M.D., Co-chairmen Sections on Dermatology and Medicine

2:00 p.m. / Election of Officers for 1970

2:15 p.m. / Symposium on Some Aspects of Collagen Diseases

The Cutaneous Histopathology of Collagen Diseases
LEWIS SHAPIRO, M.D., New Hyde Park, N. Y.; Associate Clinical Professor of Dermatology, Columbia University College of Physicians and Surgeons; and Dermatopathologist, Presbyterian Hospital, New York

This presentation will cover the histopathologic findings of the skin in diverse diffuse connective tissue (collagen) diseases, indicating the usefulness of skin biopsy in helping to establish a specific diagnosis.

Renal Problems in Collagen Diseases
RICHARD R. SORICELLI, M.D., Instructor in Medicine, Jefferson Medical College, Philadelphia, Pa.; and Consultant in Renology, Cooper Hospital, Camden

Summary not received

Immuno-Suppressive Therapy of Collagen Diseases
ROBERT CARROLL, M.D., Acting Chief of Hematology, Cooper Hospital, Camden; and Director, Blood Program, S.E. Area Red Cross

Summary not received

Dermatological Clinical Manifestations of Collagen Diseases
ROGER H. BRODKIN, M.D., Irvington; Assistant Clinical Professor of Medicine, and Acting Director, Division of Dermatology, New Jersey College of Medicine and Dentistry

The dermatologic lesions in lupus erythematosus, scleroderma, dermatomyositis and polyarteritis nodosa are described and illustrated with photographs. Gross clinical lesions, including distribution and predilection, and primary and secondary lesions are discussed and demonstrated.

3:50 p.m. / Panel Discussion

4:15 p.m. / Visit to Exhibits

Section on:

Plastic and
Reconstructive Surgery

Presiding

Vincent J. Bagli, M.D., Chairman

2:00 p.m. / Election of Officers for 1970

2:15 p.m. / Symposium on Modern Trends in Plastic Surgery

The Psychology of the Prospective Plastic Surgery Patient
DANIEL L. GOLDSTEIN, M.D., Director, Department of Psychiatry, Hackensack Hospital; and Clinical Associate Professor of Psychiatry, New Jersey College of Medicine and Dentistry

The emotional aspects of cosmetic surgery extend into many areas. This paper focuses on the psychology of the prospective patient. The development and significance of body image are discussed. Motivational factors, healthy and pathological, are reviewed as they influence both the patient and the surgeon. Supporting clinical material is presented. Many of these patients are prone to unhealthy reasons for and unrealistic expectations of reconstructive or cosmetic surgery. A psychiatric evaluation of every prospective patient is a *must* for every plastic surgeon if he is to avoid the pitfalls of an unsatisfactory psychologic result; or the release of a latent psychotic disorder; or on the other hand to help the patient make the most of his (the surgeon's) skillful efforts.

Cosmetic Plastic Surgery in 1969
Panelists:
Nasal Deformities
WILLIAM C. CONROY, M.D., Attending Plastic Surgeon, Mountainside Hospital, Montclair

Summary not received

Ear Deformities
LYNDON A. PEER, M.D., East Orange; Medical Coordinator and Director of Rehabilitation and Research Department, St. Barnabas Medical Center, Livingston

The surgical construction of a complete auricle or external ear is one of the most difficult problems in plastic surgery. Groundwork for auricle construction was established by Dr. Esser of Holland who devised his Esser Inlay method of skin grafting. This provided a skin lining for the posterior surface of the ear framework and the surface from which it was raised so that the auricle projected outward at an angle from the head.

The second problem, still unsolved, is selecting the best material for structural support of the auricle. At this time most plastic surgeons use autogenous cartilage or a silastic implant. Neither is completely satisfactory.

Eyelid Problems
ALVIN P. MANCUSI-UNGARO, M.D., Montclair; Attending Plastic Surgeon, St. Barnabas Medical Center, Livingston

Offered here is a review of methods of eyelid reconstructions and a presentation of some of the author's methods involving both functional and cosmetic repairs.

The Sagging Face
D. McCULLAGH MAYER, M.D., Rutherford; Clinical Professor of Surgery, New Jersey College of Medicine and Dentistry; and Director, Residency Training in Plastic Surgery, U. S. Veterans Administration Hospital, East Orange

Various methods of rejuvenation of the aging face are discussed with emphasis on the surgical correction, so called, "rhytidoplasty." Pre-operative preparation, anesthesia, and the surgical technic are reviewed in detail, augmented by lantern slides which demonstrate the skin incisions considered most favorable by the author in making scars less conspicuous.

Breasts—Too Large or Too Small
WALTER M. RYAN, JR., M.D., Director, Plastic Surgery Section, Jersey Shore Medical Center, Neptune

Dr. Ryan will discuss the problems of the hypoplastic breast—small, or the absence of breasts. The paper will also review the problems of the hyperplastic breasts — large breasts. Their treatment by plastic surgery will be clarified by slides and thorough discussion.

3:50 p.m. / Panel Discussion

4:15 p.m. / Visit to Exhibits

1969 Annual Meeting

MOTION PICTURE THEATRE

Sunday, Monday, and Tuesday
May 18, 19, and 20

Mornings from 10 o'clock
Afternoons from 2 o'clock

Arranged and presented through the cooperation of the Ciba Pharmaceutical Company, Summit.

Pheochromocytoma, A Cause Of Hypertension; Its Diagnosis And Treatment

Scientific and clinical guidance provided by Wiley F. Barker, M.D., University of California at Los Angeles, School of Medicine; Arthur J. Bedell, M.D., Professor Emeritus of Ophthalmology, Albany Medical College; J. Scott Butterworth, M.D., New York University Postgraduate Medical School; George F. Cahill, M.D., Columbia University College of Physicians and Surgeons; Keith S. Grimson, M.D., Duke University School of Medicine; Lloyd T. Iseri, M.D., Wayne State University College of Medicine; Meyer Melicow, M.D., Columbia University College of Physicians and Surgeons

Methods for accurate differential diagnosis of pheochromocytoma are currently available and are here presented by means of case histories reviewing typical signs and symptoms. This unusual tumor produces symptoms that mimic a number of diseases, but it most frequently resembles essential hypertension. The theoretical basis for clinical symptoms attributed to pheochromocytoma is illustrated by animated drawings.

Immunization Against Infectious Diseases

Approved by the Committee on the Control of Infectious Diseases of the American Academy of Pediatrics

This comprehensive film demonstrates methods of active immunization against: cholera, diphtheria, influenza, mumps, pertussis, plague, poliomyelitis, rabies, Rocky Mountain spotted fever, smallpox, tetanus, typhus, typhoidparatyphoid A & B, tularemia, tuberculosis, and yellow fever. Passive immunization to decrease severity of symptoms against diphtheria, gas gangrene, measles, pertussis, tetanus, infectious hepatitis, mumps, and poliomyelitis is also described.

This motion picture shows recent clinical data. It features special charts and maps showing the incidence and geographic distribution of several of these infectious diseases. Actual clinical cases demonstrate diagnostic signs. The proper times for immunization and precautions and contraindications are explained in detail.

Differential Diagnosis Of Chest Pain

Richard Ross, M.D. and G. C. Friesinger, M.D., Baltimore, Maryland

Designed as an instructional aid, this film presents practical steps for the differential diagnosis of angina pectoris-like chest pain. The technic of eliciting a meaningful patient history is introduced with lecture material and emphasized by dramatized physician-patient interviews. Relevant physical examination procedures and their rationale are discussed, as is the relationship of angina pectoris to atherosclerosis and ischemic heart disease. The film is limited to *diagnosis* and does not touch on treatment either environmental or chemotherapeutic.

The Obsolete Menopause

Allen C. Barnes, M.D. and Georgeanna Seegar-Jones, M.D., Baltimore; M. Edward Davis, M.D., Chicago; Prof. Hobert de Watteville, Geneva, Switzerland; Robert W. Kistner, M.D., Cambridge, Massachusetts; and Herbert S. Kupperman, M.D., New York

Troubles associated with menopause are caused by a reduction of estrogen and can be successfully prevented or treated by supplying the deficient hormone. In the interest of objectivity the six eminent participants represent the entire gamut of opinion on such controversial questions as whom to treat, how to treat, when to begin and end treatment, whether estrogens are carcinogenic, and the inclusion of a progestin to prevent endometrial hyerplasia. Included is a demonstration of a new device which facilitates the quantitative measurement of osteoporosis in minutes.

The Problem Of Chest Pain

Tinsley R. Harrison, M.D., Birmingham, Alabama

The setting for this film is the living room in Dr. Harrison's country home where he and Dr. Yannic Guegen have been viewing a motion picture on chest pain on a small home projector. On a second viewing of the film, they stop it from time to time so that Dr. Harrison can comment on certain features. The "inner film" presents clinical material and stylized drawings of symptoms, showing how they relate to a patient with myocardial infarction, one with angina pectoris, and a third with pain of mixed origin. Dr. Harrison's comments illuminate these stories as he brings out details concerned with differential diagnoses through use of roentgenograms, electrocardiograms and other pertinent material. Stressed throughout is the vital importance of taking a thorough history, of truly "listening to the patient."

Vertigo: Differential Diagnosis

Wallace Rubin, M.D., New Orleans; William S. Fields, M.D., Dallas; and Robert J. Wolfson, M.D., Philadelphia

The film details the procedures and methods for performing an office examination of the patient with vertigo. Onset of vertigo is shown, with manifestations of dizziness, loss of balance, and tinnitus. The general practitioner is seen performing an examination of the patient to determine whether he has true vertigo and whether it is peripheral or central in origin. The Romberg and gait tests for balance are shown and the optokinetic, positional and caloric tests for the measurement of nystagmus are demonstrated.

Suicide Prevention: The Physician's Role

Norman L. Tabachnick, M.D. and Robert Litman, M.D., Los Angeles

In the United States last year, suicide ranked among the first ten causes of death, third highest in the age group 15 to 25. This film dramatizes some of the most frequent clues to suicide and their proper management, in five authentic case histories.

VISIT THE EXHIBITS
A THREE-WAY TREAT

One of the colorful aspects of our convention is the interesting array of exhibits. This year, as usual, we have three classes—

Informational — Scientific — Technical

The exhibits help to defray the cost of your Annual Meeting. Take time to visit each booth. There is a wealth of new information available.

1969 Annual Meeting

INFORMATIONAL EXHIBITS

Sunday, May 18—10 a.m. to 5 p.m.

Monday and Tuesday, May 19 and 20

9 a.m. to 5 p.m.

Academy Of Medicine Of New Jersey

Bloomfield

Here displayed is an over-all view of the activities of the Academy of Medicine of New Jersey in providing continuing education to the physicians of New Jersey.

Children's Specialized Hospital

Westfield-Mountainside

"Every child should have a chance to *live* while he is still alive." The Children's Specialized Hospital has been serving children with long term problems since 1891. It operates only in cooperation with the referring physician and seeks to be his extended arms and eyes. The exhibit tells of services available and features a team approach to problems.

Childhood Cancer

American Cancer Society, New Jersey Division, Inc., Newark

This exhibit presents the problem of childhood cancer and the value of early diagnosis and proper treatment. It emphasizes the methods of treatment and the results which can be obtained in the most common forms of cancer in children, namely, nephroblastoma (Wilm's Tumor), neuroblastoma and soft-part sarcomas. The misconceptions which some physicians have concerning childhood cancer are frankly reviewed.

Teaching Of Pathology At Rutgers Medical School

Rutgers—The State University, New Brunswick

The teaching of pathology at this new medical school incorporates both widely established methods plus the newest concepts in teaching technics. A pictorial exhibit shows case teaching, experimentation, supervised student participation in self-teaching of gross and microscopic pathology and the use of electron microscopy as adjuncts to conventional methods of teaching general and systemic pathology.

Your Medical Assistant

New Jersey State Medical Assistants Association, Inc.

Here is a display with representatives of the association distributing information concerning the American Association of Medical Assistants; pamphlets and brochures outlining the aims and purposes of the association; and pictures of the various county chapter activities throughout the state. The booth will typify a physician's reception room.

Division Of Employment Security

State of New Jersey, Department of Labor and Industry, Trenton

For your information, here is an exhibit describing the services provided in New Jersey under the Temporary Disability Insurance Law.

Ophthalmology In New Jersey

MSNJ Committee on the Conservation of Vision

This highly informative exhibit shows screening programs and advances in ophthalmology.

Eye Drops—Complications On The Use Of

New Jersey Academy of Ophthalmology and Otolaryngology, Paterson

Photographs and subtitles with explanatory printing will bring to life problems and complications in the use of eye drops.

Illumination For Good Vision

St. Barnabas Medical Center, Livingston

Here presented is material on the theoretical basis and clinical application of good illumination; a listing of the recommended levels of illumination, and a demonstration of north daylight and incandescent light. Also included is a demonstration of recommended study and reading lamps.

Disability Evaluation Under Social Security —Medical Evaluation Criteria

Disability Determinations Service, Newark

The exhibit describes medical findings which have to be present for evaluation of disability under Social Security law.

Development Of Psychiatric Service In General Hospitals

Morristown Memorial Hospital

Outlined here are some of the problems of the development of an active psychiatric service and its integration into the structure of a community hospital. Proposed solutions to these problems are reviewed. The integral units of such a department and their function in providing mental health services are shown.

A Report To Physicians On Regional Planning For Heart Disease, Cancer, And Stroke

New Jersey Regional Medical Program, East Orange

This exhibit offers an interesting chronologic breakdown of the development of the New Jersey Regional Medical Program. It includes a brief description of the operational projects funded in New Jersey by the Division of Regional Medical Programs.

Society For The Relief Of Widows And Orphans Of Medical Men Of New Jersey

Belleville

An informational exhibit here will outline the aims and purposes of a charitable organization which provides for the health and welfare of widows and orphans of deceased members of the Society.

Medical Education In New Jersey

New Jersey College of Medicine and Dentistry, Newark

Shown here is an architectural model of the New Jersey College of Medicine and Dentistry's new campus in Newark, as well as descriptive material about the facilities, educational, research and service programs of the College.

1969 Annual Meeting

SCIENTIFIC EXHIBITS

Sunday May 18—10 a.m. to 5 p.m.
Monday and Tuesday, May 19 and 20
9 a.m. to 5 p.m.

Portal Hypertension In Schistosomiasis-Surgical Treatment In Three Siblings

James L. Baker, Jr., M.D. and Lester A. Barnett, M.D., Monmouth Medical Center, Long Branch

Here displayed is the surgical treatment, by splenorenal shunt, of portal hypertension due to schistosomiasis of three siblings of a Puerto Rican family of 10. The exhibit includes graphs and large Kodacolor photos of organs involved, as well as surgical procedure.

Urethrotomy In Recurrent Urinary Tract Infection

Guy W. Leadbetter, Jr., M.D., University of Vermont, Burlington, Vermont

The central point of interest in this exhibit is a short motion picture narrated by the author (closed sound) showing the fluoroscopic appearance of the urinary tracts of children with recurrent urinary tract infection both before and after urethrotomy. This exhibit also reports on a study of 130 female children with recurrent urinary tract infection. The patients were divided into 2 groups. Group 1 received antibacterial therapy for three months and did not undergo urethrotomy. Group 2 underwent urethrotomy and received antibacterial therapy for three months. These patients were evaluated from one to three years. The exhibit explains methods of evaluation. Results are shown as bar graphs.

Transantral Sphenoidal Hypophysectomy For Advanced Cancer

H. Randall Tollefsen, M.D.; T. R. Miller, M.D.; F. P. Gerold, M.D.; and Ernest Greenberg, M.D., Memorial Sloan-Kettering Cancer Center, New York

A simplified operation for hypophysectomy is illustrated. The transantral sphenoidal approach enables the surgeon to remove the gland *in* toto and under direct vision. Operating time is usually 45 to 75 minutes. This procedure was done on 147 patients during the last three and a half years. Surgical technic and operative specimens are shown.

A Method Of Managing Tenosynovitis And Other Hand Infections With Irrigation With Antibiotic Enzyme Solution Through Polyethylene Catheter

Sylvester J. Carter, M.D., New York Medical College, New York

This exhibit describes a new technic for managing tenosynovitis and other hand infections. The method includes prompt surgical drainage, irrigation of the tendon sheath with hydrogen peroxide and an antibiotic solution followed by continuous installation of a tetracycline and a topical enzyme solution through a polyethylene catheter. Systemic enzyme therapy may also be used. More than 20 patients have been treated in this manner. Infections have been rapidly controlled, prompt healing has occurred, hospitalization periods have been short, and functional recovery has been good. Case histories are presented.

The Nonsurgical Management Of Urinary Tract Infections In Children

Austin S. Litvak, M.D., Monmouth Medical Center, Long Branch

The purpose of the exhibit is to investigate the findings and results of conservative management of recurrent urinary tract infections in children.

Endocrine Exophthalmos—Humoral And Orbital Factors

Heskel M. Haddad, M.D., Beth Israel Medical Center, New York

Displayed here is the correlation between the clinical syndrome of endocrine exophthalmos and the responsible humoral and orbital factors. The management of the syndrome, both medical and surgical, is presented in the light of the several theories that have been proposed to explain its pathogenesis.

A Practical Dilution-Filtration Blood Culture Method

William R. Kirkham, M.D.; Hugo C. Pribor, M.D.; William R. Kozub, M.S.; and Clarence E. Chatman, M.T., Institute of Laboratory Medicine, Perth Amboy General Hospital

Shown here are the methods used in a simple and improved blood culture method which permits faster recovery, identification and antibiotic sensitivity testing of bacteria from patients with bacterermias and septicemias.

Endometrial Morphology: An Index To Contraceptive Dosage

Maxwell Roland, M.D., Family Planning Clinic, New York Polyclinic Medical School and Hospital; and Wyckoff Heights Hospital, Brooklyn and Queens Division, New York

In this exhibit, the authors show treatment with combination contraceptives and indicate how this leads to change in the endometrium. Endometrial morphologic data can be used as an index to establish an optimum dose for an oral contraceptive. This concept is demonstrated using clinical data in 264 patients for as long as 22 cycles representing a total of 1918 treatment cycles.

Treatment Of The Acute Alcohol Withdrawal State: Development Of Delirium Tremens And Convulsions—A Comparison Of Four Drugs

S. C. Kaim, M.D.; B. Rothfeld, M.D.; and C. J. Klett, Ph.D., U. S. Veterans Administration Central Office, Washington, D. C.

This exhibit reflects a large scale cooperative study of 537 patients from 23 VA Hospitals to appraise the efficacy and safety of four drugs commonly used in treating the withdrawal symptoms of the alcoholic. Chlordiazepoxide, chlorpromazine, hydroxyzine, and thiamine were evaluated against matching placebo. The development of delirium tremens and convulsions is shown to vary significantly with the treating drug used.

The Isotopist Helps The Clinician

Roger A. Berg, M.D.; David L. Bloom, M.D.; Richard J. R. Byrne, M.D.; William C. Colston, M.D.; Allan W. Newcomb, M.D.; Fred M. Palace, M.D.; and Allan J. Scher, M.D., Morristown Memorial Hospital, Morristown

Here demonstrated are various abnormal and normal isotopic scans. This illustrates how the radioisotope scan can help the clinician diagnose and treat his patients in an appropriate fashion. Brain scanning, bone scanning, and lung scans will be shown.

Parenteral Diazepam In The Treatment Of Status Epilepticus

Charles F. Nicol, M.D., Edward J. Meyer Memorial Hospital, Buffalo, New York

The focal point of this exhibit is a short motion picture narrated by the author (closed sound) showing a patient suffering a focal epileptic seizure and subsequent relief by intravenous medication. The display also details a study of 43 patients in *status epilepticus* who received injectable diazepam for treatment.

Effect Of Fluocinolone Acetonide 0.2% In Selected Chronic Dermatoses

C. H. McCuistion, M.D., Baylor University Postgraduate School of Medicine, Austin, Texas; E. P. Schoch, Jr., M.D., Southwestern Medical School, Dallas, Texas; and H. B. Christianson, M.D., Oschner Foundation Hospital, New Orleans, Louisiana

This exhibit graphically and pictorially presents the results of a double-blind study using fluocinolone acetonide 0.2 per cent and a placebo in the treatment of notoriously chronic and obstinate dermatoses. Included also are the results of a separate study comparing the effects of fluocinolone acetonide 0.2 per cent with fluocinolone acetonide 0.025 per cent.

The Effect Of Clofibrate On Hyperlipidemia

Maxwell L. Gelfand, M.D. and Michael Garber, M.D., New York Infirmary, New York

There is a close association between hyperlipidemia and coronary artery disease. The serum cholesterol and serum triglyceride level are the most frequently measured blood lipids. Key role in the reduction of hyperlipidemia is dietary control which in most instances is successful. There are, however, a number of people unable to adjust to such a strict regime and many who fail to respond even if on diet therapy. Drugs have, however, been recently introduced to combat hyperlipidemia. Clofibrate is one of the newer agents recently tested with as yet no significant deleterious effect.

Dysfunctional Uterine Bleeding (A Practical Approach To Diagnosis And Treatment)

Richard E. Sand, M.D., Encino, California

The exhibit defines a practical approach to a full diagnostic evaluation pre-treatment of dysfunctional uterine bleeding in menstruating women. The question whether women with dysfunctional uterine bleeding should have a diagnostic curettage is discussed. Results of therapy of 60 cases of established dysfunctional uterine bleeding treated with norethindrone-mestranol are presented.

Surgical Management Of Complications Of Diverticulitis In Patients Over 70

David Befeler, M.D.; William F. Mitty, Jr., M.D.; Carlo Grossi, M.D.; and Louis M. Rousselot, M.D., St. Vincent's Hospital and Medical Center of New York; and New York University Medical Center, New York

This exhibit offers data on more than 2800 patients with diverticulosis or diverticulitis. Indications for surgery, advantages of one-stage and three-stage resection, mortality and morbidity rates, and results of treatment are presented. A plea is made for continued conservatism in the management of these patients.

The Problem Of Peripheral Vascular Disease

Alexander C. Baret, M.D., Monmouth Medical Center, Long Branch

Here is a primarily educational exhibit. Right and left panels succinctly outline the problems and diagnosis of peripheral vascular disease with subjective and objective criteria, and offer a thumbnail sketch of some basic surgical approaches. The center panel displays a variety of clinical cases in color transparencies superimposed on an anatomic figure. These include aortic aneurysms, the Leriche syndrome, and segmental occlusions of the subclavian, iliac, femoral and popliteal arteries as well as popliteal aneurysms and their surgical correction. The illustrated material will encompass arteriography, *in situ* pathology, and the surgical reconstruction utilized.

Anoproctosigmoidoscopy

David Befeler, M.D., William F. Mitty, Jr., M.D., and Michael J. Lepore, M.D., St. Vincent's Hospital and New York University School of Medicine, New York

This exhibit demonstrates the technic of anoproctosigmoidoscopy as performed in the physician's office. Purpose of the display is to demonstrate the equipment, the preparation, the forms, and the positioning necessary to do a successful examination of the lower bowel. It demonstrates the basic principles of the examination including a short movie demonstrating the technic of the examination. Finally, it permits the physician to perform a sigmoidoscopy on a plastic model with simulated pathology included in the exhibit.

Amblyopia—Prevent Needless Visual Loss Through Preschool Screening

New Jersey State Commission for the Blind, Newark

This exhibit should encourage pediatricians and general practitioners to screen for amblyopia at the time of routine physical examinations. Symptoms and screening procedures are described. Literature is available. The ultimate aim of this display is the prevention of needless visual loss through early detection.

Glaucoma—Prevent Needless Visual Loss Through Routine Tonometry

New Jersey State Commission for the Blind, Newark

It is hoped that this display will encourage routine tonometry at the time of routine physical examinations. Posters and mannequin heads are used and an ophthalmologist will demonstrate tonometry. The overall purpose is the prevention of needless visual loss through early detection.

Relief Of Anxiety In Patients Undergoing Cataract Surgery

A. A. Cinotti, M.D.; L. M. Greenberg, M.D.; and J. Akhtar, M.D., New Jersey College of Medicine and Dentistry, Jersey City

The heart of this exhibit is a narrated (closed sound) film showing cataract extraction as done by the authors. The objective of the film is to demonstrate to the non-ophthalmologist the salient features of this procedure. The exhibit describes the results of a double-blind study demonstrating the effects of chlordiazepoxide in calming the anxious patient during this procedure.

Use Of Cardioversion In The Smaller Medical Center

Robert A. Turkel, M.D., Westcoast Cardiology Center, Tampa, Florida

The heart of this exhibit is a short, narrated (closed sound) film showing cardioversion as accomplished in our hospital. Emphasis is given to making the procedure as practical and efficient as possible by using a minimal amount of personnel and hospital resources. The use of injectable diazepam as premedication is described.

How To Get A Colon Clean—With Less Effort

Mauvine Reed Barnes, M.D., University of Pennsylvania Hospital, Philadelphia

This display offers a comparison of radiographs of barium enema examinations of the colon made following preparation by laxatives and diet. It shows a distinct advantage over those made after the use of castor oil and enemas.

Mental Retardation—Chromosome And Newborn Errors In Metabolism

Miles E. Drake, M.D., Vineland; Chairman, MSNJ Committee on Mental Retardation

In this display, the committee demonstrates the more common errors in metabolism and chromosomal defects leading to mental retardation.

Hydronephrosis In Irradiated Carcinoma Of The Cervix

Anthony R. Fernicola, M.D., St. James Hospital, Newark

The behavior of hydronephrosis is demonstrated in patients irradiated for carcinoma of the cervix. X-ray evidence is presented to show spontaneous disappearance of hydronephrosis in these patients. Spontaneous regression of hydronephrosis is apparently the result of a reversible radiation ureteropathy heretofore unrecognized as a clinical entity. There is pointed out the differentiation between obstructive ureterecstasis and pyelecstasis (which is irreversible and requires surgery) and non-obstructive ureterecstasis and pyelecstasis (which is reversible and non-surgical). These observations indicate that a decision to "buy time" can spare countless women the necessity of corrective major surgery for hydronephrosis.

Antibiotic Dosage For Renal Insufficiency And Dialysis Therapy

Norma J. Goodwin, M.D. and Eli A. Friedman, M.D., Downstate Medical Center, Brooklyn, New York

A single 75 milligram dose of sodium colistimethate was administered to 39 subjects with varying degrees of renal function, 17 of whom were undergoing dialysis therapy. Recommendations were made for six patient groups and for the treatment of overdosage. The protocol utilized is adaptable to the study of other antibiotics. Such data are necessary for patients with renal insufficiency requiring antibiotic therapy.

Cosmetic Plastic Surgery—Reconstructive Surgery For Cosmesis

Walter M. Ryan, Jr., M.D.; Monmouth Medical Center, Long Branch, and Jersey Shore Medical Group, Neptune

Recent advances in cosmetic plastic surgery are here reviewed. Large and medium color photographs light up individual problem cases. There will be continuous projection of colored slides of cases requiring reconstructive plastic surgery for cosmesis. The aim is to show plastic surgery in reconstruction of defects and deformities so as to produce a better cosmetic result.

Clinical Use Of Silicone Rubber Ureteral Splint Tubes Inserted Cystoscopically

Paul D. Zimskind, M.D. and J. Louis Wilkerson, M.D., Jefferson Medical College and Hospital, Philadelphia

An original technic is illustrated for cystoscopic insertion of silicone rubber ureteral splint tubes for long-term drainage. This procedure has been used at Jefferson Medical College Hospital for the past three and a half years in the treatment of carcinomatous obstruction of the ureter, ureterovaginal fistula, severe ureteral stricture and hydronephrosis of pregnancy with sepsis. Following insertion of the ureteral splint tube, which drains into the bladder, patients are freely ambulatory. The exhibit contains illustrations and descriptions of the insertion technic and illustrative case reports.

Testicular Prosthesis: A Simplified Surgical Technic

Donald R. Krawitt, M.D., Mt. Sinai School of Medicine, New York

This exhibit consists of a Mark IV projector showing the exact surgical technic of testicular prosthesis. Also displayed are data on the indications for this procedure.

Urologic Endoscopic Photography

Donald R. Krawitt, M.D. and Herbert Brendler, M.D., Mt. Sinai School of Medicine, New York

Shown here will be a display of how urologic endoscopic motion pictures can aid in teaching and documentation. In addition, this can be applied to specialties where endoscopy is essential, like bronchoscopy and sigmoidoscopy. The exhibit consists of three Mark IV projectors showing endoscopic movies and how it was done.

Ischemic Lower Extremity

Howard C. Baron, M.D. and Richard T. Purdy, M.D., Jewish Memorial Hospital, New York

The exhibit illustrates the diagnosis and operative treatment of the ischemic lower extremity. Several operative procedures utilizing autogenous tissue for the revascularization of the lower extremity are illustrated and described in detail. Results utilizing the saphonous vein as autogenous graft or carbon dioxide gas-thromboendarterectomy are presented.

Use Of Polaroid Radiography

Mauvine Reed Barnes, M.D.; Donald DePoto, M.D.; and Charles White, R.T., University of Pennsylvania Hospital, Philadelphia

Polaroid radiography offers a definitive and rapid method of evaluating parts of the body under investigation by x-ray. It makes possible operative cholangiography without the added necessity of dark room equipment. Other uses are also described.

Reconstructive Vascular Surgery

Eli Curi, M.D.

The purpose of this display is to illustrate the effectiveness of the surgical management of acute and chronic vascular problems involving various areas of the vascular system. It shows pre-operative and post-operative angiograms, vascular pathology in different stages, and completed reconstructive vascular procedures. The statistical data of the results are also illustrated. The conclusion is that reconstructive vascular surgery can effectively restore normalness in the vascular system.

The Management of Newborns in Cardiac Distress

Milton Prystowsky, M.D.; Peter Poulos, M.D.; Jose Antillon, M.D.; Asuncion Abella, M.D.; Jerome Mathias, L.X.T.; and Alice Forster, R.N., Babies' and Presbyterian Hospitals of United Hospitals of Newark

Physicians should be aware of the need for early detection of neonatal cardiac problems. This display will emphasize the aggressive medical and surgical approach to such problems in order to salvage infants who might otherwise die. The exhibit offers a display of cases of neonatal cyanotic and acyanotic congenital heart malformations, such as, pulmonary stenosis or atresia, transposition of the great vessels, Tetralogy of Fallot with pulmonary atresia, interventricular septal defect with patent ductus arteriosus, coarctation of aorta syndrome, and tricuspid atresia. On one panel are listed the symptoms, signs, ECG, and chest roentgenograms. On another panel are cineangiograms projected with rear view camera in the center and flanked on the left side by caricatures of sick infants illuminated by blue and red lights to define cyanotic and pink babies. On the right side are caricatures of these same babies following medical and surgical treatment. One panel shows catheterization data and medical and surgical methods of treatment for these infants.

Symposium

"Diagnosis of Life and Death"

Sunday, May 18 — 9:30 A.M.
Garden Room — Haddon Hall

1969 Annual Meeting

TECHNICAL EXHIBITS

Sunday, May 18 — 10:00 a.m. to 5:00 p.m.
Monday and Tuesday, May 19 and 20 — 9:00 a.m. to 5:00 p.m.

In Appreciation

The Medical Society of New Jersey acknowledges with thanks the generous contributions of GEIGY PHARMACEUTICALS, ROCHE LABORATORIES and SMITH KLINE & FRENCH LABORATORIES. These grants are being used to underwrite, in part, the educational programs presented through the scientific sessions.

Abbott Laboratories #8

Abbott Laboratories will feature Normosol® solutions, modern successors to normal saline and dextrose solutions, providing physiologic concentration of the principle ions of normal plasma; and Iberet® —500, a comprehensive hematinic with controlled-release iron, B-complex, and 500 mg. of vitamin C to insure optimal iron absorption.

American Medical Building Guide #44

Turn Key Medical Building Format

Apache Corporation #62

Apache Oil Programs, Inc., a subsidiary of Apache Corporation, organizes, offers and manages drilling programs for individuals whose taxable incomes render attractive (and justify) the inherent risk of oil participation.

Astra Pharmaceutical Products, Inc. #21

Information and descriptive literature pertaining to Xylocaine® (lidocaine) and Citanest® (prilocaine) local and topical anesthetics, and iron preparations Astrafer® (dextriferron) for intravenous use and Jectofer® (iron sorbitex) for intramuscular administration will be available at the Astra booth.

Ayerst Laboratories #58

Summary not received

Barrington Research Associates #46

Summary not received

Bergen Drug Company, Inc. #32

Bergen Drug Company's Computerized Management and Patient Billing System is operated by the firm's data processing division. Physicians are offered, in addition to billing, a wide range of practice management information and analyses plus some unique aids in collection. Bergen has been processing pharmacy receivables for over five years under the name of "Tiptop."

Blair & Co., Inc. #5

Stocks and Securities

E. & W. Blanksteen #13 and #14

E. & W. Blanksteen have been official insurance brokers for The Medical Society of New Jersey since 1930 for the administration of officially approved plans of disability, major medical, and life insurance. Information and literature, as well as personal consultation, are available at this booth.

Joseph A. Britton Agency #12

Summary not received

Ciba Pharmaceutical Company #38

Ciba Professional Service Representatives will be pleased to discuss Esimil.®

Computer Consultants Corporation #22

Summary not received

Coca-Cola USA #40

Ice cold Coca-Cola will be served at the Annual Meeting, through the courtesy and cooperation of the Coca-Cola Bottling Company of South Jersey, and Coca-Cola USA.

Thomas A. Edison Industries #37

Edison Voicewriter

Encyclopaedia Britannica, Inc. #31

Encyclopaedia Britannica, Great Books of the Western World, Britannica Junior, and other related materials.

Equity Funding Corporation of America #61

Equity Funding Corporation offers a leveraged type of investment program designed for the sophisticated investor. "Programs for the aquisition of mutual funds and life insurance" can be geared for the Keogh Retirement Act. Pick up a free prospectus.

Hospital Service Plan Of New Jersey #10

Pre-Paid Non-Profit Hospital Insurance.

Lederle Laboratories #33

Lederle Laboratories is pleased to support The Medical Society of New Jersey by its presence at this meeting. Our trained representatives will be glad to discuss our well-known brand-name drugs such as Declomycin® and Achromycin,® the world's foremost broad-spectrum antibiotics; Aristocort,® the widely known steroid; Myambutol,® a new chemotherapeutic agent for the control of tuberculosis; and our other products applicable to your practice. Information is also available on our many other services to medicine.

David and Charles Levinson #24

On display: Medco Products—The Medcolator: Electrical muscle stimulator, for relief of muscle pains, sprains, dislocations and other trauma of the muscle and skeletal system. The Medco-Sonlator Twin: A diagnostic and therapeutic instrument, combining synchronized pulsed ultra sound with Medcolator current in continuous, pulse, surge with reciprocal settings. The Medcotherm: An electronic instrument, designed for simultaneous application of controlled moist infrared heat and electrical stimulation. The Achilleometer: An instant Achilles Reflex Test for testing thyroid function. Direct reading on an expanded scale, transistorized, battery operated. Quick, accurate, ready for instant use.

Eli Lilly and Company #30

Featured at the Lilly booth will be Loridine,™ Keflin,® C-Quens,® Cordran,® and Darvon.®

3M Business Products Sales, Inc. #4

Information will be available on 3M Copying Machines, Billing Systems, and Background Music.

Mead Johnson Laboratories #20

The Mead Johnson Laboratories' exhibit has been arranged to give you the optimum in quick service and product information. To make your visit productive, specially trained representatives will be on duty to tell you about Vasodilan,® Enfamil,® and Oracon.®

Medical-Surgical Plan Of New Jersey #11

The Plan's Physician Relations Representatives will gladly answer your questions on the prevailing fee program, Medicare complementary programs, or other matters pertaining to the Plan's policies, procedures or payments.

Medi Card, Inc. #60

Medi Card is a single, dignified professional care credit card providing the cardholder the convenience of paying for medical, dental, hospital, and prescription drug services anywhere in the United States on an orderly, long-range, twenty-four-month based payment plan. It assures the physician payment within ten days of receipt of a properly executed Medi Card draft.

Merck Sharp & Dohme #7

The Merck Sharp & Dohme exhibit has been designed to supplement the physicians' therapeutic armamentarium. Technically trained personnel are present to discuss the scope and variety of services offered.

Milex Of Delaware Valley #39

Milestro,® a new specific for atrophic vaginitis, will be presented. Also reviewed will be developments in pelvic cancer detection and the Amino-Cerv,® specific for the post-operative cervix. The Milex Patient Level Sex Educational Series will be discussed.

New Jersey Bell Telephone Company #56 and #57

Telephone equipment and services will be available at the New Jersey Bell booth.

New Jersey State Medical Assistants Association Inc. Message Center

Two members of the New Jersey State Medical Assistants Association, Inc. will be stationed at the Message Center from 10 a.m. to 5 p.m., Saturday, May 17, 1969 through Tuesday, May 20, 1969. Medical Assistants from the entire state of New Jersey will be on hand to participate in this service.

Telephone messages will be directed in the proper channels and a glance at a nearby bulletin board will advise those who have messages to be picked up.

Ormont Drug & Chemical Co., Inc. #59

Information will be available on Panjet, Sterneedle, and PPD.

Ortho Pharmaceutical Corporation #2

Ortho is proud to present the most complete line of medically accepted products for the control of conception. Of special note are the most recent products of the Ortho Research Foundation — Ortho-Novum® 1mg tablets; Ortho-Novum® 2mg tablets; Ortho-Novum SQ® tablets Ortho-Novum 1/80* □ 21 Tablets, Delfen® contraceptive cream and Delfen® contraceptive foam. Also on display will be our well known products for the treatment of various forms of vaginitis. Your questions will be welcomed by our representatives.

Parke, Davis & Company #15

Parke-Davis is proud of more than a century of service to the medical profession. Our representatives consider it a pleasure to contribute to the success of your meeting. They will be present to discuss the quality products from Parke-Davis, and welcome your comments or inquiry.

Chas. Pfizer & Co., Inc. #16

Displayed here will be Vibramycin,® Vistaril® and Diabinese.®

Pro Services, Inc. #26

PRO Services, Inc. is a full service financial organization specializing in tax sheltered retirement programs. It is the administrator for over 125 professional society Keogh programs, handles over 80 mutual funds, and through Cannon & Company, a wholly owned brokerage subsidiary, manages general securities accounts.

Programmed Learning Inc. #43

The automated reading program ("Speed Reading") will be discussed at this booth.

The Prudential Insurance Company Of America Coffee Lounge

Presenting the Medicare picture as Part B Carrier for our State and Intermediary for 33 Hospitals, 35 Home Health Agencies and 56 Extended Care Facilities. Representatives will be available to answer your questions and otherwise assist you with Medicare matters.

A. H. Robins Company, Inc. #29

You are cordially invited to visit the A. H. Robins display and meet our representatives who will welcome the opportunity to discuss products of interest with you. Recent new product releases are Dopram® Injectable (doxapram hydrochloride), Repoise® maleate (butaperazine maleate), Sulla® (sulfameter) and Tybatran® (tybamate).

William H. Rorer, Inc. #19

William H. Rorer, Inc. takes pride in exhibiting its fine pharmaceutical products at this convention. Our representatives will gladly discuss Maalox,® Ascriptin,® Ananase,® Quaalude® and our other products with you.

Sandoz Pharmaceuticals #18

Sandoz Pharmaceuticals cordially invites you to visit our display where we are featuring Mellaril,® Sansert,® Cafergot P-B,® Fiorinal® and Fiorinal® with codeine. Any of our representatives in attendance will gladly answer questions about these and other Sandoz products.

W. B. Saunders Company #28

Saunders will have on display a complete line of their medical books, including many new titles and new editions published since last year's meeting.

Searle/BMI #50

Searle/BMI manufactures and distributes blood analysis systems incorporating reagent packages with disposable capability and direct readout of clinically significant constituents. Eleven tests are currently available with an additional six scheduled for release in 1969. Searle/BMI also makes a radioisotope counter with digital readout for T-3, T-4, blood volume, and Schilling tests. Prothrombin time instrumentation and accessory sample measurement and reagent dispensing components are included in an expanding line of diagnostic systems for the office and laboratory.

G. D. Searle & Co. #63

You are cordially invited to visit the Searle booth where our representatives will be happy to answer any questions regarding Searle "products of research." Featured will be information on Ovulen®-21, Ovulen®-28, Enovid,® Aldactazide,® Flagyl,® Lomotil,® Pro-Banthine® and other drugs of interest.

Siemens Medical Of America, Inc. #25

Siemens Medical will display many advancements in diagnostic and therapy equipment. Our representatives will be on hand to demonstrate our equipment and discuss practical applications with you. We believe a few minutes at our booth will prove to be well spent.

Stuart Division, Atlas Chemical Industries, Inc. #64

The Stuart booth will feature Sorbitrate,® Mylanta,® Dialose® and Dialose Plus.®

Syntex Laboratories, Inc. #52

Physicians are cordially invited to visit the Syntex booth for prescribing information on our complete line of oral contraceptives and topical steroid preparations.

C. O. Truxton, Incorporated #9

Our exhibit will consist of many items in the layered tablet category, which will enhance the needs of the modern physician. During the first half of 1969, we have added a delayed action capsule of Papaverine,® under the trade name of Pavacot T.D.® This will be shown. All of these products are designed for the physician to add to his armamentarium for the treatment of his patients.

The Upjohn Company #23

Professional representatives of The Upjohn Company are eager to contribute to the success of this meeting. They are here to discuss products of Upjohn research designed to assist you in the practice of your profession. They welcome your inquiries and comments.

Warren-Teed Pharmaceuticals Inc. #1

Our representatives will welcome the opportunity to discuss Kaon,® Kaochlor® and Modane® with you.

Winthrop Laboratories #35

Winthrop Laboratories cordially invites you to visit their booth where they will feature: Talwin® — Brand of Pentazocine (as lactate); NegGram® — (brand of nalidixic acid); and Isuprel® — (brand of isoproterenol) Mistometer.®

Wyeth Laboratories #17

Wyeth will feature Ovral® each tablet contains 0.5 mg. norgestrel (containing 0.25 mg. d-norgestrel) with 0.05 mg. ethinyl estradiol, Wyeth; Serax® (oxazepam) Wyeth, capsules.

42nd ANNUAL MEETING

Woman's Auxiliary to The Medical Society of New Jersey

Saturday through Tuesday
May 17, 18, 19, 20, 1969

Chalfonte-Haddon Hall
Atlantic City

Schedule of Events

Saturday, May 17, 1969

1:00 p.m. to 4:30 p.m.—Registration for Art Show
(Lobby floor, Haddon Hall)

"1:00 p.m.—Golden Merit Award Ceremony
(Rutland Room, First floor, Haddon Hall)

"3:00 p.m.—Auxiliary President's Report to MSNJ House of Delegates
(Windsor Room, Haddon Hall)

Sunday, May 18, 1969

9:30 a.m. to 4:30 p.m.—Registration
(Lobby floor, Haddon Hall)
Tickets for Tea and Fashion Show

10:00 a.m. to 4:30 p.m.—Sale of Tickets
(Lobby floor, Haddon Hall) for President's Luncheon—Monday
(Pennsylvania Room, Haddon Hall)
All doctors' wives invited

10:00 a.m.—Art Exhibit
—County Press and Publicity Books Exhibit
—County Activities Pictorial Display
(Lobby floor, Haddon Hall)

10:30 a.m.—Pre-convention Board Meeting
(Roberts Room, Office floor, Chalfonte)

12:30 p.m.—Fellowettes' Luncheon
(Blue Room, Office floor, Chalfonte)

2:30 p.m.—Tea and Fashion Show
(Vernon Room, Haddon Hall)

*4:00 p.m.—Address of Incoming MSNJ President
—General Session
(Windsor Room, Haddon Hall)

*6:00 p.m.—Reception for President-elect Bertha
(Pennsylvania Room, Haddon Hall)
Admission by badge

*8:00 p.m.—Reception and Buffet Dinner Honoring Technical Exhibitors
(Vernon Room, Haddon Hall)
Tickets at MSNJ Registration Desk

Monday, May 19, 1969

8:15 a.m. to 9:00 a.m.—Continental Breakfast
(Hallway, 13th floor, Haddon Hall)

8:15 a.m. to 4:30 p.m.—Registration
(Lobby floor, Haddon Hall)

9:00 a.m. to 12 noon—Tickets on sale
(Lobby floor, Haddon Hall) for President's Luncheon—Monday
(Pennsylvania Room, Haddon Hall)

9:00 a.m. to 12 noon—General Session
(West Room, 13th floor, Haddon Hall)

9:00 a.m. to 4:30 p.m.—Sale of Dinner-Dance tickets

12:30 p.m.—Annual President's Luncheon
(Pennsylvania Room, Haddon Hall)

2:30 p.m.—General Session reconvenes

*7:00 p.m.—Dinner-Dance
(Pennsylvania Room, Haddon Hall)

Tuesday, May 20, 1969

8:00 a.m.—Breakfast for new county presidents
(Mandarin Room, 13th floor, Haddon Hall)

9:00 a.m. to 10:00 a.m.—Continental Breakfast
(Hallway, Tower floor, Haddon Hall)

9:00 a.m. to 12:00 noon—Registration
(Lobby floor, Haddon Hall)

10:00 a.m.—Post-convention Board Meeting
(West Room, 13th floor, Haddon Hall)

Convention Committee

Chairman—Mrs. Samuel J. Kaman

Co-Chairman—Mrs. John F. Perez

*MSNJ events to which the Auxiliary Members are cordially invited.

ROOM RESERVATIONS

Complete and mail this form for your room reservation

203rd ANNUAL MEETING — THE MEDICAL SOCIETY OF NEW JERSEY

May 17-20, 1969

Reservation Desk, Chalfonte-Haddon Hall, Atlantic City, New Jersey

PLEASE RESERVE THE FOLLOWING ACCOMMODATIONS — THIS RESERVATION WILL BE ACKNOWLEDGED
If room is not available at rate requested, please check here
authorizing us to make reservation at next available rate. ☐

No. of Rooms	**HADDON HALL** All Rooms Air Conditioned Single, Bath, 1 Person	Twin Bedroom, Bath 2 Persons	**CHALFONTE** Air Conditioned Rooms Available Single, Bath 1 Person	Twin Bedroom, Bath 2 Persons
	Without Ocean View ☐ 13 ☐ 15 ☐ 18 ☐ 20	*☐ 17 ☐ 20 ☐ 22	☐ 12 ☐ 14 ☐ 16	☐ 17 ☐ 19
	Side Ocean View ☐ 24 ☐ 26 ☐ 28	☐ 26 ☐ 28 ☐ 30	☐ 20 ☐ 22	☐ 23 ☐ 25
	Ocean Front ☐ 32 ☐ 34	☐ 34 ☐ 36	☐ 22 ☐ 24 ☐ 28	☐ 25 ☐ 27 ☐ 31
	Double & Parlor	☐ 46 ☐ 56 ☐ 58		
	Double & Parlor Ocean Front	☐ 72		☐ 64

EACH ADDITIONAL PERSON IN DOUBLE ROOM $5.00 EUROPEAN PLAN *Roomettes
MODIFIED AMERICAN PLAN (BREAKFAST & DINNER) ADD $8.00 PER DAY, PER PERSON
FOR AMERICAN PLAN (3 MEALS) ADD $10.00 PER DAY, PER PERSON ☐

I will share a room with.....

Day and date of arrival.....Departure.....

Name.....

Address.....

PLEASE PRINT Plus 5% City Tax

NOTE: As check-out hour is 3:00 p.m., rooms may not be ready earlier.

COMMITTEE ON ANNUAL MEETING

JEROME G. KAUFMAN, M.D., Chairman, Maplewood
EDWARD E. P. SEIDMON, M.D., Vice-Chairman, Plainfield
MILTON ACKERMAN, M.D., Atlantic City
PETER H. MARVEL, M.D., Northfield
JAMES A. ROGERS, M.D., East Orange
ROBERT E. VERDON, M.D., Cliffside Park
MARCUS H. GREIFINGER, M.D., Ex-Officio, Newark
MRS. MARION R. WALTON, Convention Manager, Trenton

SUBCOMMITTEE ON SCIENTIFIC EXHIBITS

MILTON ACKERMAN, M.D., Chairman, Atlantic City
ARTHUR BERNSTEIN, M.D., Maplewood
SIDNEY S. GIRSH, M.D., Atlantic City
THOMAS K. RATHMELL, M.D., Trenton
JOHN J. THOMPSON, M.D., Caldwell
ROBERT E. VERDON, M.D., Cliffside Park

SUBCOMMITTEE ON SCIENTIFIC PROGRAM

JAMES A. ROGERS, M.D., Chairman, East Orange
CHAIRMEN AND SECRETARIES of Scientific Sections

NEW JERSEY DOCTORS' NOTEBOOK

Trustees' Minutes

February 16, 1969

A regular meeting of the Board of Trustees was held on February 16, 1969 at the Executive Offices in Trenton. Detailed minutes are on file with the secretary of your county medical society. A summary of the significant actions follows:

AMA-ERF Fund Raising Appeal . . . Approved a request to cooperate with the AMA Circulation and Records Department in the preparation and release of a special AMA-ERF fund-raising appeal to the physicians in New Jersey. (The AMA will pay the cost of mailing.)

Conference of Presidents . . . Rescinded its action of January 19, 1969 that the Spring Conference of Presidents and Presidents-Elect of Component Societies be held at Rider College, and directed that the meeting be held in the Executive Offices, March 16, 1969.

. . . Authorized Dr. Nicholas A. Bertha, President-Elect to represent the Board of Trustees at the morning session of this Conference.

Liaison with SAMA . . . Referred a resolution from the AMA (adopted at the Clinical Convention in Miami Beach, December 1968) urging every county and state medical society to initiate and maintain an active liaison with students at medical schools within their jurisdiction, preferably through functioning chapters of SAMA, to the Committee on Medical Education.

Council on Legislation . . . Approved the report of the January 30, 1969 meeting of the Council on Legislation, including the following recommended official position of MSNJ (as amended by the Board) on bills of medical import:

S-37 —To authorize the Trustees of the New Jersey College of Medicine and Dentistry to acquire for their use the Jersey City Medical Center. *NO ACTION*

S-39 —To provide penalties for first, second and third offenses of violations of the narcotics drug act. *APPROVED*

S-45 —To permit county appropriations for the benefit of brain-injured persons to defray expenses incident to diagnosis, treatment and training. *APPROVED*

S-66 —To prohibt littering of waterways and adjacent shores and beaches and to regulate marine toilets. *APPROVED*

S-75 —To provide for the establishment of a Medical and Dental College of South Jersey by Rutgers University. *APPROVED*

S-149—To require the fluoride contents of any public potable water supply to be maintained between eight tenths and one and two-tenths milligrams per liter enforced by the Department of Health. *NO ACTION*

The Board amended the position of the Council concerning S-149 to one of *APPROVED.*

S-152—To provide for increases in maximum weekly workmen's compensation benefits for permanent partial disabilities, increases in funeral allowances, free choice of physician, a Board of Workmen's Compensation Appeals and other changes. *APPROVED*

S-153—To provide for the licensing and registration
A-121—of electrologists by the Board of Medical Examiners. *APPROVED*

S-157—To permit the Board of Medical Examiners to grant a license for practice of medicine and surgery without further examination where an applicant shows he has been examined and licensed in a foreign country. *ACTIVE OPPOSITION*, because it would circumvent the orderly and dependable procedure for licensing of physicians adopted by the State of New Jersey as a means of protecting the public against unqualified practitioners. It would impose upon the State Board of Medical Examiners the almost impossible responsibility of ascertaining the standards of licensure applied in all foreign countries, and of deciding whether those standards may be accepted as equivalent to those which New Jersey imposes, or to those of other states whose licensees New Jersey accepts on a basis of reciprocity.

S-165—To repeal the tax on gross receipts of unincor-
A-124—porated businesses. *APPROVED*

S-177—To provide for civil commitment of drug ad-
A-23 —dicts. *APPROVED*

S-179—To provide that any applicant for a license to practice medicine and surgery who, in addition to other required proofs necessary to be admitted to examination, shows he has engaged in the practice for 10 years and has reached a position of eminence in his profession shall be granted a license without further examination upon payment of the required fee. *DISAPPROVED*, because it would abrogate the present discretionary powers of the

Board on the basis of objective evidence and would impose an obligation to make subjective judgments as to what constitutes "proof," "reputable practice," and "conceded eminence and authority in his profession."

S-185—To provide increased penalties for violation of the narcotics drug act and to provide that such penalties shall not be remitted nor shall any person sentenced thereunder be eligible for parole. *APPROVED*

S-187—To require every district and regional board of education to appoint an advisory committee on narcotics for each of the high schools in a school district, to make studies and advise what measures should be taken to eliminate narcotics from such schools. *NO ACTION*

The Board amended the position of the Council concerning S-187 to one of *APPROVED.*

S-188—To provide for the distribution of a supply of fluoridated tablets by the Department of Health where applied for by a Board of Health when any child under 9 shall request same on an application signed by the parent or guardian of the child. *DISAPPROVED,* because it is impractical of implementation, since there is in New Jersey only one county board of health established by statute — Hudson.

The Board directed that the Council's position on S-188 be referred back to the Council on Legislation for reconsideration.

S-189—To provide that no hospital or medical service corporation or insurance company shall be entitled to be subrogated to any claim of an insured as against any third party other than the employer of the insured or the employer's carrier or any hospital or physician's lien except payments made under the Workmen's Compensation Law. *DISAPPROVED,* in support of the position of Medical-Surgical Plan of New Jersey and Hospital Service Plan of New Jersey.

S-192—To provide for public representation on all professional boards. *ACTIVE OPPOSITION,* because professional unqualified lay members would encumber the boards, with no appreciable advantage to the public.

S-198—To authorize the Board of Medical Examiners to permit municipal hospital employees who hold M.D. or D.O. degrees to practice in the hospital without a license. *DISAPPROVED,* because MSNJ feels that it is contrary to the public interest to entrust patients to the care of unlicensed physicians other than interns and residents in an approved training program.

S-209—To remove restrictions against the practice of medicine by persons in the employ of a municipal hospital who hold M.D. or D.O. degrees, and where a physician is duly licensed in any foreign country where requirements for licensing are not substantially lower than New Jersey and while teaching and not in private practice. *DISAPPROVED,* because MSNJ feels that it is contrary to the public interest to entrust patients to the care of unlicensed physicians other than interns and residents in an approved training program.

S-210—To restrict in State Institutions the availability of a patient's medical record for public use except by his consent or upon court order. *APPROVED*

S-211—To authorize the issuance of limited licenses to practice medicine and limited licenses as assistants in medicine. *ACTION DEFERRED* until more information is obtained from one of the sponsors to clarify this bill.

S-222—To authorize the chief executive officer of a state or county institution for the mentally ill or retarded or of a state or county penal or correctional institution to give consent for treatment of incompetent patients or inmates under 21. *APPROVED*

S-246—To exempt law and medical libraries of attorneys and of physicians and surgeons from assessment and taxation as personal property used in business. *APPROVED*

S-275—To require medical service corporations to pay the Commissioner of Banking and Insurance a fee of $0.02 per subscriber, member or employee covered under contracts. *NO ACTION*

S-276—To require hospital service corporations to pay the Commissioner of Banking and Insurance a fee of $0.02 per subscriber, member or employee covered under contracts. *NO ACTION*

S-301—To license and regulate medical care facilities; transfers powers and duties to the Department of Health from the Department of Institutions and Agencies; amends the act concerning hospital service corporations and hospital service plans and reconstitutes the board of trustees of the Hospital Service Plan to limit representation of the health profession and health care institutions to one-third. *DISAPPROVED, WITH ACTIVE OPPOSITION IF BILL MOVES,* because it poses a threat to the free practice of medicine and the continued life of the Medical-Surgical Plan of New Jersey.

S-337—To provide for the construction of Community Mental Health Center to be managed by the New Jersey College of Medicine and Dentistry. *APPROVED*

S-350—To authorize the school medical inspector to accept the report of physical examination of a pupil by his treating physician. *APPROVED*

S-356—To provide a penalty for operation of a motor vehicle while the under the influence of marijuana. *APPROVED*

S-365—To provide for the confidentiality of information and data secured by and in possession of hospitals or extended care facility utilization review committees. *ACTIVE SUPPORT*

S-366—To provide that medical records or photographic reproductions shall be retained by a hospital for seven years following the most recent discharge of a patient or until the confined person reaches age 23, whichever is later; to require retention of a discharge summary sheet for 20 years and x-ray films for 5 years. *APPROVED*

S-387—To define "resident" in the act regulating rest homes for sheltered care and to provide that nothing in the act shall prevent care of residents in emergency cases where the attending physician certifies that continued care is in the best interest of the resident. *ACTION DEFERRED* until a copy of the bill is available for analysis.

S-404—To provide that any person who advertises, sells or offers any person any compound intended for household use which contains poisonous ingredients and does not label such package clearly is a disorderly person. *ACTION DEFERRED* until a copy of the bill is available for analysis.

S-408—To provide that the Board of Trustees of the New Jersey Medical and Dental College shall consist of 9, in place of 7, members. *ACTION DEFERRED* until a copy of the bill is available for analysis.

S-413—To provide that the State Sanitary Code shall not contain any regulation which requires or directs the mandatory fluoridation of any public potable water supply. *APPROVED*

S-424—To provide that any applicant for a chiropractic license must have completed no less than one and one-half years of study in accredited school or college of arts and sciences before commencing study in the approved school of chiropractic. *NO ACTION*

S-427—To provide for establishment of regional evaluation centers for mentally retarded, physically handicapped, emotionally disturbed, socially maladjusted and multiple handicapped children. *NO ACTION*

A-3 —To require licensing of the practice of medical technology; to create a Medical Technology Advisory Committee. *DISAPPROVED,* because there is currently in New Jersey and across the nation a serious ancillary personnel manpower shortage. The excessively proscriptive provisions of Sections 6, 7, and 8 of this bill will only serve to aggravate and intensify the dearth of qualified personnel and will have an untoward effect upon the delivery of quality health care.

A-21 —To authorize persons who successfully complete a course of training in a public or private hospital or who have assisted physicians for not less than two years to carry out limited ancillary technical procedures in assistance of physicians. *ACTIVE SUPPORT*

A-23 —To provide for civil commitment of drug ad-
S-177—dicts. *APPROVED*

A-70 —To allow residents of boarding homes for sheltered care or rest homes to receive nursing care upon certification of the attending physician. *APPROVED*

A-105—To provide that alcohol in excess of 0.05% but less than 0.10% in a motor vehicle operator's blood shall not give rise to a presumption that his driving ability was or was not impaired by consumption of alcohol. *APPROVED*

A-106—To authorize the Commissioner of Health to prohibit, restrict or condition, permanently or for a specified time, any activity contributing to air pollution; to prohibit, permanently, the construction or operation of an industrial process if its contribution to air pollution would constitute an unreasonable risk and to provide for public hearing after public notice upon the proposal to exercise such power. *APPROVED*

A-107—To authorize a governing body to prescribe penalties for violation of air pollution control ordinances but not in excess of those prescribed in Chapter 212, Laws of 1954, Section 19. *APPROVED*

A-108—To authorize establishment of regional air pollution control districts. *APPROVED*

A-114—To establish a Noise Control Act; to empower the Commissioner of Health to promulgate codes, rules and regulations for the control of noise. *APPROVED*

A-120—To provide for commitment of convicted sex offenders; to provide for physical and mental examinations and special treatment; to provide for payment of maintenance costs by the treated person or his family. *ACTION DEFERRED* until a copy of the bill is available for analysis.

A-121—To provide for the registration and licensing
S-153—of electrologists by the Board of Medical Examiners. *APPROVED*

A-124—To repeal the tax on gross receipts of unincor-
S-165—porated businesses. *APPROVED*

A-126—To increase penalties for violations of the narcotic drugs act and to provide for examination of suspected narcotic and drug addicts by two qualified physicians upon court initiative or request of counsel for the defendant. *NO ACTION*

A-137—To authorize gifts of all or part of a human body after death for advancement of medical science or replacement or rehabilitation of diseased or worn out parts or organs. *APPROVED*

A-145—To authorize hospital service corporations to include health care services or supplies as are approved for such inclusion in their contracts by the Commissioner of Banking and Insurance. *DISAPPROVED,* because this bill would enable hospital service plans to provide medical services, a result which is invasive of the historical function of the medical services corporation and has dangerous implication to the private practice of medicine.

A-170—To provide that no municipality shall treat its water supply with fluoride unless first authorized by the legal voters. *APPROVED*

A-180—To delete from the act concerning assistance for dependent children that provision which provides that a determination of a right to financial assistance by reason of unemployment or underemployment of parents shall not constitute such persons as eligible for coverage under the "New Jersey Medical Assistance Act." *APPROVED*

A-181—To delete from the public assistance act that provision which provides that any grant of old age assistance shall not make recipients thereof eligible for coverage under the "New Jersey Medical Assistance Act." *APPROVED*

A-188—To authorize hospital service corporations to issue additional health care services as approved by the Commissioner of Banking and Insurance. *DISAPPROVED,* because this bill would enable hospital service plans to provide medical services, a result which is invasive of the historical function of the medical services corporation and has dangerous implications to the private practice of medicine.

A-189—To authorize medical service corporations to issue benefits for health care services, other than medical services, as approved by the Commissioner of Banking and Insurance. *DISAPPROVED,* because the medical service corporation was founded under the auspices of The Medical Society of New Jersey. Its sole function is to provide benefits for medical services and it should restrict itself to this type of service. "Other health care services" might include services not medical in nature.

A-200—To provide for licensing, inspection, and regulation of medical care facilities, to create a Commission on Hospital Care and Related Services and to provide for enforcement. *NO ACTION*

A-214—To provide that any condition or impairment of health to a uniformed member of a paid fire department caused by hypertension, heart disease, or tuberculosis shall be deemed to be an occupational disease. *DISAPPROVED,* because it involves diagnosis by legislative enactment rather than by medical investigation.

A-232—To provide that no dog or other animal caught and detained shall be sold or otherwise made available for the purpose of experimentation. *DISAPPROVED,* because it would hinder progress of scientific animal research, with jeopardy to the public welfare.

A-271—To establish a Division of Narcotic and Drug Abuse Control in the Department of Health. *ACTION DEFERRED* until a copy of the bill is available for analysis.

A-272—To provide that prepackaged meat shall be in containers which are colorless and transparent on all sides. *ACTION DEFERRED* until a copy of the bill is available for analysis.

A-279—To increase maximum weekly Workmen's Compensation benefits for death, permanent total and temporary disability to $90; to increase maximum weekly benefits for permanent partial disability to $45 and to increase number of weeks for enucleation of an eye, 25% increase in amputation awards and other changes. *ACTION DEFERRED* until a copy of the bill is available for analysis.

A-285—To provide that no hospital emergency receiving room shall be open for treatment unless there is in attendance at least one person on the staff who speaks English and is capable of interpreting same in the language of the licensed medical practitioner in charge of such room. *APPROVED*

Council on Mental Health . . . Approved the report of the February 5, 1969 meeting of the Council on Mental Health, including the following recommendations:

1. That the Committee on Alcoholism become an inactive Committee, with chairman and members remaining intact. They will not be required to meet unless upon specific direction of the Council, or at the call of the chairman.

2. That the name of the Committee (Drug Addiction) be changed to "Special Committee on Drug Abuse."

3. That the Board of Trustees be requested to authorize reproduction in *The Journal* of the article, "What Is A Psychiatrist?" (A pamphlet published by the Assembly of District Branches of the American Psychiatric Association)

Committee on Medical Defense and Insurance . . . Approved the report of the January 26, 1969 meeting of the Committee on Medical Defense and Insurance, including the following recommendations:

1. That the Society approve a Conversion Provision Rider presented by Nationwide Insurance Company.

2. That Nationwide Insurance Company be given authorization to attach this Conversion Provision Rider to all endorsed policies of MSNJ members.

3. That the proposed rate increase of Employers Insurance of Wausau for 1969-1970 be approved by the Board of Trustees. (The proposal is that rates for all classes be increased by 10 per cent.)

4. That a copy of the Membership Insurance Programs booklet be sent to each physician-member of MSNJ.

Community Blood Council of Greater New York . . . Directed that an invitation from the Community Blood Council of Greater New York to MSNJ to become a member agency be declined with thanks, since the *Ad Hoc* Committee on Blood Banking was in the process of developing the New Jersey Blood Bank Association.

Committee on Blood Banking . . . Directed that, since there are five physicians on the *Ad Hoc* Committee on Blood Banking, each representing his own organization, none of whom officially represents MSNJ, a request be made to the Chairman of the Committee that Sylvan E. Moolten, M.D. of New Brunswick and Bernard Ehrenberg, M.D. of Elizabeth be appointed as official representatives of MSNJ.

Health Facilities Planning Council . . . Authorized a $5,000 contribution to the Health Facilities Planning Council for the fiscal year 1969-1970.

. . . Indicated that it could not officially authorize funds for separate regional groups, since the original mandate of the House of Delegates did not make such a provision.

Relative Value Index . . . Directed that the Board of Trustees introduce a resolution at the 1969 House of Delegates recommending reconsideration of a Relative Value Index for New Jersey, tabled by the 1962 House, and that the matter be referred to the Board with authorization to prepare a revised Relative Value Index for presentation to the 1970 House of Delegates.

Medicare Fee Disputes . . . Requested that the Judicial Council advise county judicial committees and component societies of the proper mechanism to be used in considering complaints involving Medicare fees.

Sheen Award . . . Directed that the name of David B. Allman, M.D., of Brigantine, be placed in nomination to receive the 1969 Dr. Rodman E. Sheen and Thomas G. Sheen Award ($10,000 prize given annually to an American physician in recognition of outstanding contribution to medicine) which will be presented July 13, 1969 during the AMA Convention in New York.

Support The

Annual Meeting Exhibits

Inspect Each One

Technical

Scientific

Informational

Communicable Diseases In New Jersey

The following communicable diseases were reported to the Division of Preventable Diseases during the month of February:

	February 1969	*February 1968*
Aseptic Meningitis	9	4
Primary Encephalitis	5	0
Post-infectious encephalitis	0	0
Hepatitis: Total	112	109
Infectious	96	102
Serum	16	7
Malaria		
Military	16	11
Civilian	1	0
Meningococcal meningitis	13	2
Mumps	210	618
German measles	79	208
Measles	56	58
Salmonella	44	46
Shigella	23	5

Infectious Hepatitis

Between February 4 and 17, 1969, infectious hepatitis occurred in eleven individuals who ate food prepared at the delicatessen shop of a large supermarket in Bergen County. The index case was the 26 year old manager of the delicatessen department who became ill on January 11, 1969. The fellow employees developed symptoms of hepatitis on February 7 and 12th. All of the other nine cases of hepatitis developed in persons who ate food prepared by the delicatessen shop and served at a party on January 11, 1969. Four of these victims were hospitalized. Age range was 22 to 30. Mean age was 24 years with five males and four females. All of these patients had dark urine. Other common symptoms included loss of appetite, nausea, malaise, jaundice, and fever. The attack rate of hepatitis among the 23 people eating food at the party was 39 per cent. All of them denied another source of hepatitis, i.e., history of recent known contact with jaundiced persons, ingestion of raw shellfish, transfusions, or injections.

Food histories were obtained from *all* persons who ate food at the party. Of the 20 food items served, the item with the greatest attack rate difference between the eaters and non-eaters was the "Sloppy Joe" sandwich where the attack rate was 47 per cent. These

were triple decker sandwiches made with rye bread, cole slaw, sliced roast beef, corn beef, white turkey meat, and Russian dressing. Although the index case prepared the Russian dressing from commercially processed mayonnaise and ketchup, he does not recall making the sandwiches. Twelve physicians and twelve hospitals serving the local communities were contacted regarding other cases of hepatitis. No other cases could be related to the supermarket.

Viral Hepatitis in New Jersey

There were 1820 cases of viral hepatitis reported in New Jersey during 1968. This was 19 per cent more than the number of cases reported in 1967. Of these, 1464 were classified as infectious hepatitis and 356 were parenterally transmitted-hepatitis. Of the latter, 186 cases occurred among narcotic addicts whose infection resulted from contaminated needles. Another 17 of these were among laboratory technicians, physicians, and nurses whose infections were probably transmitted parenterally by hospital equipment. The remaining 153 infections were by means of transfusions of blood and blood products.

Forty-six per cent of the total cases of viral hepatitis were in the age range of 15 to 24. There was more than a 2 to 1 predominance of males to females in this age group. The high incidence of hepatitis in this age range is a reflection of parental narcotic-associated hepatitis. The attack rate of viral hepatitis for the entire state was 25 per 100,000 population. In many of our cities, the attack rate was much higher. For example Newark, Jersey City and Paterson had respective attack rates per 100,000 of 114, 56, and 37.

Only eleven per cent of the cases of infectious hepatitis had a history of ingestion of raw shellfish. There was no localization of these cases by month or location and thus no shellfish associated hepatitis outbreak was implicated during 1968.

The largest outbreak in New Jersey during 1968 occurred in a State institution for retarded males. Seventy-eight cases were reported from January to July. This represented an attack rate of 6.3 per cent for residents of the institution and 0.6 per cent for employees. Quarantine, gamma globulin, and sanitary education were used to contain the outbreak.

PHYSICIANS SEEKING LOCATION IN NEW JERSEY

(Listed in order of receipt)

The following physicians have written to the Executive Offices of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly of them.

ANESTHESIOLOGY—Claude Magnant, M.D., 710 Zumbro Drive, NW, Rochester, Minnesota 55901. Temple, 1963. Board Eligible. Group or partnership. Available July 1969.

INTERNAL MEDICINE—Harvey I. Hurwitz, M.D., Apt. L-2, 121 South Highland Avenue, Ossining, New York 10562. Boston University, 1962. Board eligible. Group. Available.

David A. Berkowitz, M.D., 2408A Snark Street, Griffiss AFB, New York 13440. New York Medical, 1963, Board eligible. Group or partnership. Available July 1969.

David Lemper, M.D., 8700 West Wisconsin Avenue, Milwaukee, Wisconsin 53226. University of Pennsylvania, 1965. Subspecialty, nuclear medicine. Solo, group or partnership. Available July 1969.

OBSTETRICS AND GYNECOLOGY — Donald S. Cohen, M.D., 2512A Atlas Drive, Griffiss Air Force Base, New York, 13440. Columbia, 1962. Board certified. Partnership or group. Available July 1969.

Harold M. Yatvin, M.D., Kirk Army Hospital, Aberdeen Proving Ground, Aberdeen, Maryland 21001. New York Medical, 1962. Board eligible. Group. Available August 1969.

Jerry A. Wider, M.D., 315 Congressional Lane. Rockeville, Maryland 20852. Columbia, 1963. Board eligible. Partnership or Group. Available July 1969.

Ronald P. Portadin, M.D., 296-B Bizerte Road, Fort Lee, Virginia 23801. Georgetown, 1962. Board eligible. Associate. Available July 1969.

OPHTHALMOLOGY — Franklin L. Bocian, M.D., 54 Orange Street, Brooklyn, New York 11201. Downstate Medical Center (NYU), 1964. Solo or associate. Available July 1969.

ORTHOPEDICS—Seymour Einhorn, M.D., 2nd General Hospital, Box 24, APO 09180, New York. New York Medical, 1957. Board Certified. Partnership. Available September 1969.

PATHOLOGY—Martin Berman, 6309 Winner Avenue, Baltimore, Maryland 21215. Downstate Medical Center (NYU), 1961. Board certified. Group, partnership, institution. Available July 1969.

SURGERY—Teofilo Po, M.D., 5235 Post Road 2-C, Riverdale, New York 10471. University of Santo Tomas, Manila, 1958. Board certified. Solo or group. Available April 1969.

THORACIC—CARDIOVASCULAR SURGERY—John K. Garan, M.D., Medical College of Georgia, Augusta, Georgia 30902. University of Paris (France) Medical School, 1961. Partnership, Group, Associate. Available July 1969.

UROLOGY—William A. Reed, Jr., M.D., 168 Grove Park, Fort Dix 08640. Georgetown, 1958. Board certified. Partnership or group. Available December 1968.

Albert P. Parasuk, M.D., 350 East 17th Street, New York, New York 10003. George Washington, 1964. Associate. Available July 1969.

Alfred R. Bozzo, M.D., 3106 Holly Street, Alexandria, Virginia 22305. Georgetown, 1962. Board eligible. Solo or partnership. Available July 1969.

Myron M. Smith, M.D., 1115 Sixth Street, SW, Minneapolis, Minnesota 55414. NYU (Downstate) 1962. Board Eligible. Partnership. Available July 1969.

Who Are The Medicare Scapegoats?

Former Health, Education and Welfare Secretary Wilbur Cohen estimated that the Medicaid program may cost the federal government $3 billion in the fiscal year 1970-71. The estimate for the 1968 fiscal year is $2.1 billion. The original estimate for that year was $1.7 but that proved too low and the administration asked for $500 million more.

The proportion of people 65 and over enrolled in the doctor bill insurance part of Medicare went up from 92 to 95 per cent during the recent 6-month open enrollment period. About 700,000 older people who had missed out on their first chance to enroll signed up between October 1967 and April of 1968. Now, 18.6 million of the 19.6 million persons 65 and over in the nation are enrolled for Medicare voluntary medical insurance.

Medicare received $3.1 billion in fiscal 1967 and disbursed $2.6 billion. Mr. Ball estimates that for the next 25 years "the program will have a favorable actuarial balance — namely, that total income over the 25 years ahead is expected to exceed total outgo."

Cohen told a House appropriations subcommittee that HEW is now making an intensive investigation of reported abuses by some physicians in federal medical programs. He said a number of allegations had been made but that he will not make an overall statement until the investigation is completed.

"A typical kind of allegation concerns a doctor who goes into a nursing home—I will be just hypothetical about this — and is there for an hour and then sends in a bill for an injection of something for every one of 50 people in the institution.

"Then we have had cases of bills being submitted in which (the evidence suggests) the volume of services that he wants to be paid for is beyond the ability of a particular person to handle. Well, he comes back to that allegation and says, 'I have a nurse and I have an assistant' and so on. So we have to look into each one of them on their merits. We are doing that now.

"The popular criticism usually has to do with the individual fee. I really don't think that is the major issue. The real issue is not so much the fee or the price per unit, but the number of units that the person is saying he delivered."

Cohen said he did not think such practices are widespread but that:

"We have enough to be very much concerned about it."

ANNOUNCEMENTS

Emergency Room Training For Physicians

With the approval of the Board of Trustees, January 19, 1969 (March 1969 JOURNAL, p. 134), the United States Public Health Service, in cooperation with the New Jersey State Department of Health and the Division of Emergency Medical Service, will present a statewide training program for emergency room physicians, to be held on two successive Wednesdays in each of the five medical judicial districts in New Jersey. The program (received too late for inclusion in the March JOURNAL) was presented in the First District on March 26 at the Morristown Memorial Hospital, Morristown, and on April 2 at St. Elizabeth Hospital in Elizabeth. The lectures, which will be repeated in each District (as scheduled below) are as follows:

Second District

April 9 *St. Joseph Hospital, Paterson*

9:00 a.m. Care of Simple Wounds
10:00 a.m. Management of Multi-System Injury
1:00 p.m. Treatment of Burns
2:00 p.m. Resuscitation—restoration of airway, shock, hemorrage, fluid replacement
3:00 p.m. The Unconscious Patient

April 16 *Hackensack Hospital, Hackensack*

9:00 a.m. Cardiac Emergencies
10:00 a.m. Psychiatric Emergencies
11:00 a.m. Infant Emergencies
1:00 p.m. Cardiopulmonary Resuscitation

Third District

April 23 *Perth Amboy General Hospital, Perth Amboy*
April 30 *St. Francis Hospital, Trenton*

Fourth District

May 7 *Burlington County Memorial Hospital, Mount Holly*
May 14 *Monmouth Medical Center, Long Branch*

Fifth District

May 21 *Cooper Hospital, Camden*
May 28 *Atlantic City Hospital, Atlantic City*

What's Bugging New Jersey?

On April 23, at the Greenbrier Inn, Route 1, New Brunswick, the New Jersey Public Health Association (with MSNJ as a cosponsor) will present an all-day program, beginning at 9:30 a.m., covering the ecology of mosquito-borne disease. The program's aim is to relate the overall water management problems in New Jersey to the public health, sociologic, and economic aspects of mosquitoes with reference to disease transmission and to the "nuisance" aspect of mosquito infestation. A panel of experts has agreed to participate. The luncheon speaker will be C. C. Johnson, Jr. of the Department of Health, Education and Welfare. His topic is "The Responsibility of Society for Protection of Society." The registration fee of $6 includes luncheon. For further information write to Dr. Oscar Sussman, New Jersey Public Health Association, 118 West State Street, Trenton, New Jersey 08618.

AMA International Conference

Former Secretary of State Dean Rusk will be among the authorities participating in the American Medical Association's Conference on International Health. This will be held on May 22 and 23 at the LaSalle Hotel in Chicago. Its theme: "U.S. Efforts in International Health Today and Tomorrow."

Conferees will review present American endeavors in international health. The effort will be to delineate more clearly how American medicine can establish and support an increasingly meaningful role in this area.

Mr. Rusk, now a Distinguished Fellow of the Rockefeller Foundation, will address the May 22 luncheon. Others of international reputation also will speak during the conference. General subject areas include:

The role of research and development in international health.

Delivery of health services in the international field.

Significance of manpower development in international health.

Fireside workshops Thursday evening, May 22, will consider international medical education, activities of church-related groups abroad, sponsorship of volunteer physicians overseas (including the AMA's program in Vietnam), and collection and distribution of medical supplies.

The program is open to individuals with an interest in international health. Additional details may be obtained from the Department of International Health, American Medical Association, 535 North Dearborn St., Chicago 60610.

Research Instrumentation Course Now Available

A three-week summer course in research instrumentation will be conducted at Polytechnic Institute of Brooklyn for all who need a working knowledge of electronic instrumentation as applied to problems in research. The program runs from July 19 to August 9, 1969, on Brooklyn campus at 333 Jay Street. Applicants will be accepted on tuition-paying basis at $500, covering all laboratory fees, textbooks, and special notes.

Medical research workers will find the course valuable and are also invited to apply. There are no specific prerequisites beyond a basic understanding of college physics.

The text for the course is "Electronics for Scientists" by Malmstadt, Enke and Toren. This unique volume presents both reference material and detailed experiments for laboratory work. It will remain a valuable addition to the student's reference library long after the course has been completed.

If interested, file your application by June 1. Inquiries may be directed to: Prof. Kenneth Jolls, Polytechnic Institute, 333 Jay Street, Brooklyn, New York 11201.

Write A Paper And Go To Paris

A round trip ticket to Paris, plus all hotel expenses, awaits the winner of the manuscript selected by the Obstetrics and Gynecology group of the International College of Surgeons. The manuscript, which must not exceed 5000 words, must be on an obstetrical or gynecologic topic. To get more details, write to Dr. Edward Eichner at 10605 Chester Avenue, Cleveland, Ohio 44106.

OBITUARIES

Dr. C. Paul Cameron

On February 28, 1969, Dr. Clarence Paul Cameron, a well-known Atlantic County practitioner, died at the Shore Memorial Hospital at the age of 59. A graduate of the class of 1936 at Temple University Medical School, he devoted his professional life to family practice in the best traditions of that field. He became chief of medicine at the Shore Memorial Hospital. Dr. Cameron served four years on active military duty in the medical corps of the Army of the United States.

Dr. Angelo B. Capaccio

A brief but busy life was terminated on January 29, 1969 with the death, from a heart attack, of Dr. Angelo B. Capaccio. A 1960 graduate of the New Jersey College of Medicine and Dentistry, Dr. Cappacio served his internship in Jersey City, and then had a psychiatric residency at St. Vincent's Hospital in New York City. He became a staff psychiatrist at the Essex County Overbrook Hospital in Cedar Grove, and subsequently a private practitioner of psychiatry in Jersey City. He was on psychiatric services at St. Francis Hospital and at the Medical Center in Jersey City, and was active in committee work with the Hudson County Medical So-

ciety. Dr. Capaccio was only 35 years old at the time of his sudden death.

Dr. John C. Clark

John C. Clark, M.D., died on February 24, 1969 at the age of 59. He was a urologist in Philadelphia and became physician to the Youth Study Center there. During World War II, he saw active duty as a major in the medical corps of the Army of the United States. Later he became the physician-in-chief at the Buttonwood Home for the Aged in New Lisbon, New Jersey. Dr. Clark was a graduate of the Jefferson Medical College, class of 1935, and was active in our Burlington County Medical Society.

Dr. Harry E. DiGiacomo

Harry E. DiGiacomo, M.D., died suddenly on February 5, 1969 at the age of 60. Dr. DiGiacomo earned his M.D. at the medical school of Georgetown University in 1936. He was a general practitioner who affiliated with Columbus Hospital, St. Michael's Hospital, and the Martland Division of the Hospital of the New Jersey College of Medicine and Surgery.

Dr. Norman Hersh

A swift and fatal illness took the life of Norman Hersh, M.D. on February 8, 1969. Only 39 years old at the time of his death, Dr. Hersh, already certified in pediatrics, was doing a graduate fellowship in child psychology at the Psychiatric Institute and Presbyterian Hospital in New York. He had practiced pediatrics in Wayne, New Jersey since the completion of his internship and residency in 1957.

Dr. Emanuel R. Kant

He always said that he wanted to die with his boots on. And on Washington's Birthday 1969, Dr. Emanuel R. Kant did just that. He was making rounds at the Perth Amboy General Hospital when a swift and sudden heart attack took his life. Dr. Kant was born in 1913 and received his medical degree at Northwestern in 1940. He did graduate work, then a residency and a fellowship in gynecology and obstetrics, and became a board diplomate in both fields. He was senior attending at Perth Amboy General Hospital. During World War II he compiled a distinguished military record.

Dr. William R. Little

One of the Delaware Valley's pioneer pediatricians, William R. Little, M.D., died at the age of 80 after a long illness. Death occurred on February 8, 1969. Dr. Little received his M.D. degree from the University of Virginia in 1915. He did general practice for several years and then began to concentrate on the then brand new specialty of pediatrics. In World War I, he was a captain in the Army Medical Corps. He was affiliated with the Mercer Hospital in Trenton.

Dr. Noah Myerson

Long a prominent Hudson County urologist, Noah Myerson, M.D. died suddenly on February 5, 1969, of a coronary thrombosis. Born in 1900, Dr. Myerson was a graduate of New York University Medical School, class of 1924. He was active in the affairs of the Hudson County Medical Society, serving in most of its offices, and had a term as president of that component in 1950. He was equally active in the American Urological Association, and for many years, was the chief medical examiner of Hudson County. For a busy decade, Dr. Myerson was the medical director of the North Hudson Hospital.

Dr. A. Ross Pittman

A man of many parts, A. Ross Pittman, M.D., had been a missionary, a patron of the arts, and a psychiatrist. Born in 1883, he was 86 years old when he died on February 24, 1969. A 1916 graduate of the medical school of the University of Tennessee, he served as a medical missionary in India from 1918 to 1929. When he returned to the U.S.A., he came to our Trenton State Hospital and served that institution until his retirement in 1957. A board diplomate in psychiatry, he was also a Fellow of the American College of Physicians.

Dr. Ernest F. Purcell

Born during the presidency of William McKinley, Ernest F. Purcell died on February 24, 1969. A graduate of Hahnemann Medical College, class of 1918, Dr. Purcell first did general practice and then began to specialize in gynecologic surgery and obstetrics. He was on the staff of the Helene Fuld Hospital in Trenton, with courtesy privileges at other Trenton hospitals. Dr. Purcell was a pioneer member of the American College of Obstetricians and Gynecologists. He was 73 years old at the time of his death.

Dr. Ernest Reeves

One of the senior members of the Passaic County Medical Society, Ernest Reeves, M.D., died on January 8, 1969, at the age of 84. Dr. Reeves was an early board diplomate in otolaryngology and headed that service at St. Mary's Hospital in Passaic. Born in 1885, he received his M.D. in 1908 at the University of Budapest. He was also a Fellow of the American College of Surgeons.

Dr. Dargo Rynar

The adventurous and useful life of Dargo Rynar, M.D., came to an end on February 23, 1969, with the death on that day of one of Ocean County's senior practitioners. Born in Germany in 1897, he earned his medical doctorate in 1921 at the University of Freiburg. He set up a private practice in Baden and was one of that section's best known practitioners until 1933. When the Nazi government started its war on the intellect, Dr. Rynar, one step ahead of the storm troopers, escaped to Switzerland. In 1937 he came to the U.S.A. and did general practice in the Lakewood area. Dr. Rynar was also an accomplished cellist. In his college days he played with Albert Einstein in a local chamber music group.

Dr. Otto Walker

Born in Vienna in 1902, Otto Walker, M.D. received his medical degree at the University of Vienna in 1929. From then until 1938 he did general practice in the Austrian capital. In 1938 he emigrated to the United States and established a family practice in Carteret. He was active in the affairs of our Middlesex County component, and was a member of the American Geriatric Society. Dr. Walker died on February 13, 1969 at the age of 67.

Cigarette Advertising Under Fire

A Federal Communications Commission proposal to ban cigarette advertising on radio and television put the issue squarely before Congress again. Actually, in 1965, the Congress had outlawed any federal or state controls on cigarette advertising, though they did make it mandatory that cigarette packages carry the warning: "Caution: Cigarette Smoking May Be Hazardous to Your Health." But the American Medical Association House of Delegates, at its December 1968 meeting, refused to condemn cigarette advertising on TV. Instead, it urged that AMA members "play a major role against cigarette smoking by personal example and by advice regarding the health hazards of smoking." The adopted resolution also made it Association policy that the AMA "discourage smoking by means of public pronouncements and educational programs" and "take a strong stand against smoking by every means. . . ."

Anticipating "censorship" charges — which came promptly from the tobacco industry, the FCC said in announcing its proposal:

"We believe that in the case of such a threat to public health, the authority to act is really a duty to act. We stress again that our action is limited to the unique situation and product, that we are unaware of any other product commercials calling for such action, and expressly disclaim any intention to so proceed against other product commercials."

MEETINGS OF MEDICAL INTEREST

This listing has been compiled by the Academy of Medicine of New Jersey. For additional information, including exact time of meetings, write to the society or hospital listed.

1969
April

8 **Bergen County Medical Society**

8 **Cumberland County Medical Society**

9 **The Academy of Medicine of New Jersey**
Section on Urology
Marriott Motor Inn
Saddle Brook
"Burpeau Memorial Dinner"

9 **Gloucester County Tuberculosis and Health Association**

9 **Mercer County Medical Society**
State Hospital
Trenton

9 **Middlesex County Medical Society**

9 **Ocean County Medical Society**

10 **The Academy of Medicine of New Jersey and Burlington County Medical Society**
Symposium on Diabetes

12 **Kessler Institute For Rehabilitation**
Pleasant Valley Way
West Orange
"Congenital Amputee Clinic" (9 a.m. to noon)

15 **Warren County Medical Society**

16 **New Jersey Rehabilitation Commission Golden Jubilee Celebration**
Brunswick Inn
East Brunswick
Luncheon, followed by program on "Criteria for Disability Evaluation"

16 **Essex and Morris County Medical Societies with Sandoz Pharmaceuticals**
Sandoz Auditorium
Hanover
"Treatment and Management of Puberty, Pimples, and Adolescence"

16 **The Academy of Medicine of New Jersey**
Hoffman-LaRoche
Nutley
Symposium: "The Management of Urinary Tract Infections"

16 **The Academy of Medicine of New Jersey**
Section on Dentistry
VA Hospital, East Orange
Symposium: "The Dentist's Role In Facial Pain And Its Management"

17 **The Academy of Medicine of New Jersey**
Burlington County Memorial Hospital
Mount Holly
Paul Kimball Hospital
Lakewood
Community Hospital
Toms River
Institute for Medical Research
Camden
Symposium: "Cancer of the Uterus and Cervix"

17 **Gloucester County Medical Society**

17 **Morris County Medical Society**

23 **Bergen Pines County Hospital**
Division of Internal Medicine
Paramus
"Porphyrin Metabolism"

23 **New Jersey Association of School Physicians**
Labor Education Center, Rutgers
New Brunswick
"Economic and Legislative Aspects of School Health Programs"

A "cold" fact



NTz® delivers relief of nasal symptoms

The *first spray*—1 or 2 squirts—of NTz opens the inferior part of the common meatus. The *second spray,* a few minutes later, shrinks the turbinates to promote adequate sinus drainage and ventilation—to help prevent sinusitis. Dosage may be repeated every three or four hours.

The fact is, NTz is more than a simple vasoconstrictor. It contains:

Neo-Synephrine® HCl 0.5%, a decongestant of unexcelled efficacy (in full adult strength) to shrink nasal membranes and allow comfortable breathing.

Thenfadil® HCl 0.1%, a topical antihistamine to help relieve itching and rhinorrhea.

Zephiran® Cl 1:5000, an excellent wetting agent and antiseptic preservative to aid rapid spread of components.

NTz, for temporary relief of nasal symptoms, is well tolerated, but overdosage should be avoided.

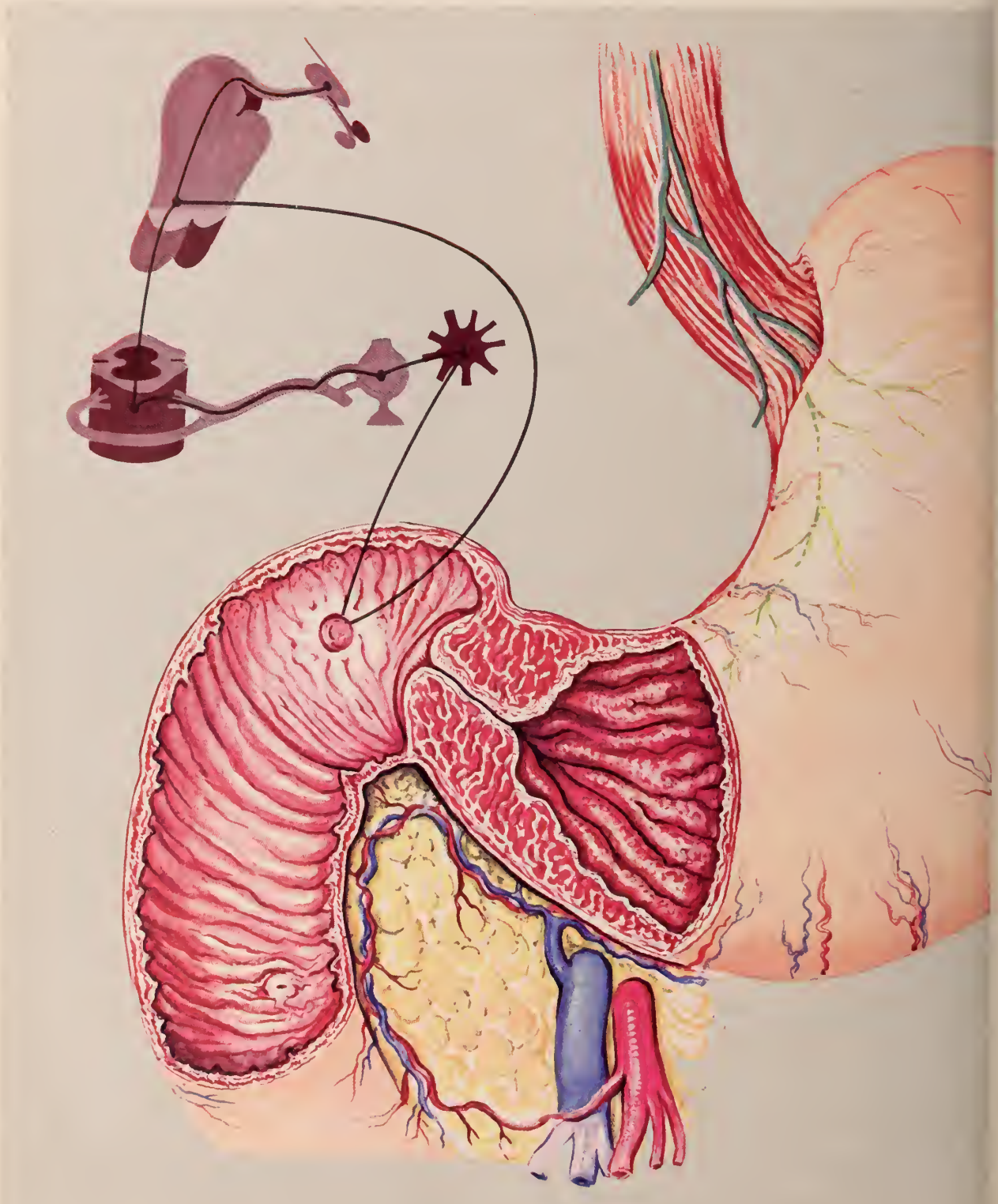
Available: NTz Nasal Spray in squeeze bottles of 20 ml.; NTz Solution in bottles of 1 oz. with dropper.

Winthrop

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(1286M)

Healing the ulcer crater



Pro-Banthīne®

brand of
propantheline bromide

blocks ulcerogenic autonomic impulses

Therapeutic Activity—Pro-Banthīne blocks ulcerogenic impulses at both parasympathetic effector sites and ganglia and at sympathetic ganglia.

This dual action, a capacity quite beyond that of belladonna derivatives, has been shown repeatedly to reduce gastric secretion, to suppress gastrointestinal motility and to relieve ulcer pain.

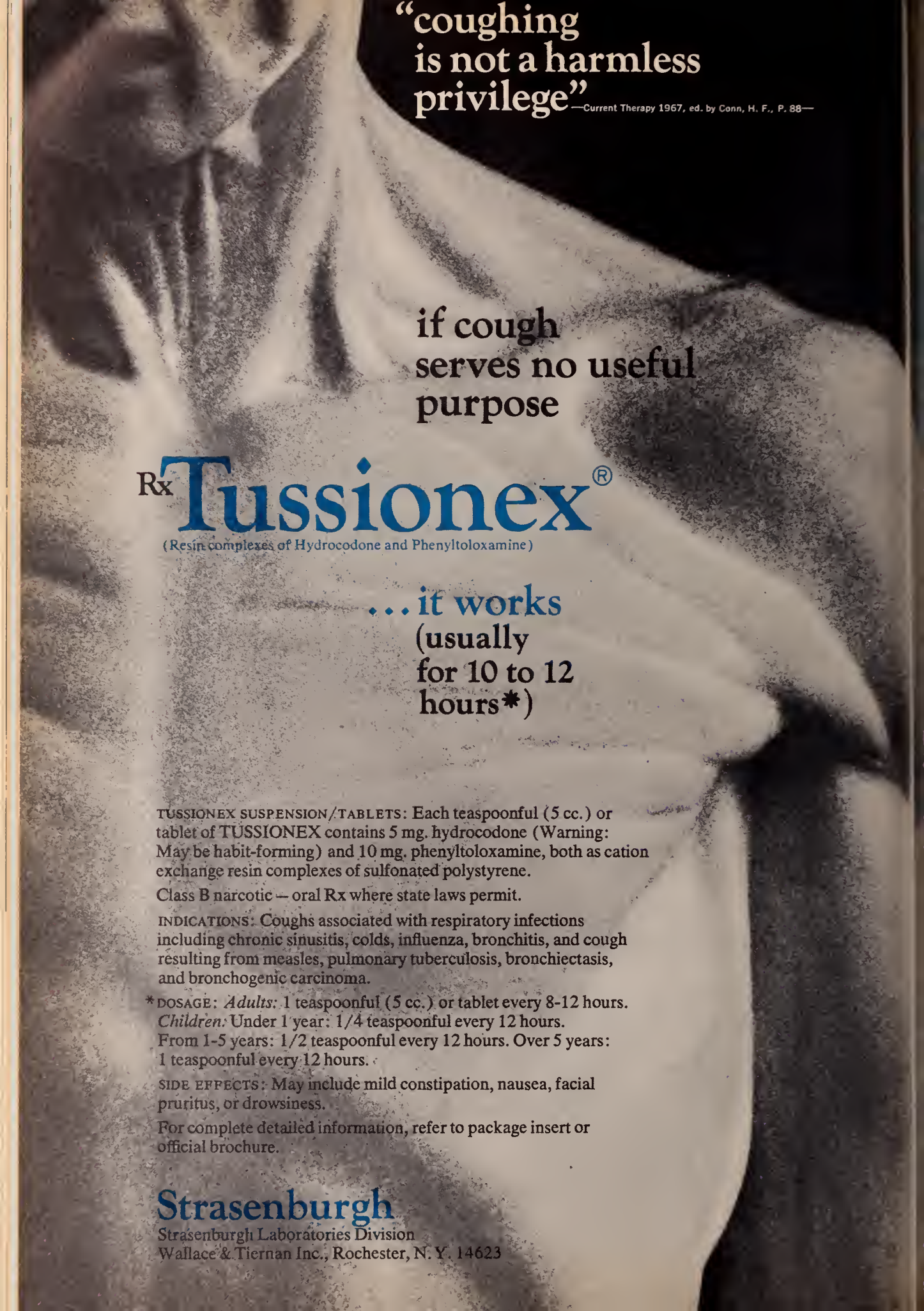
Healing Environment—Thus, Pro-Banthīne, together with other standard measures, creates a favorable environment to hasten healing of the ulcer.

So widely is this ability recognized that for years Pro-Banthīne has been the most widely prescribed medication for treating peptic ulcer.

Indications: Peptic ulcer, gastroenteritis, pylorospasm, biliary dyskinesia, functional hypermotility and irritable colon.
Contraindications: Glaucoma, severe cardiac disease.
Precautions: Since varying degrees of urinary hesitancy may occur in elderly men with prostatic hypertrophy, this should be watched for in such patients until they have gained some experience with the drug. Although never reported, theoretically a curare-like action may occur with possible loss of voluntary muscle control. Such patients should receive prompt and continuing artificial respiration until the drug effect has been exhausted.
Side Effects: The more common side effects, in order of incidence, are xerostomia, mydriasis, hesitancy of urination and gastric fullness.
Dosage: The maximal tolerated dosage is usually the most effective. For most adult patients this will be four to six 15-mg. tablets daily in divided doses. In severe conditions as many as two tablets four to six times daily may be required. Pro-Banthīne (brand of propantheline bromide) is supplied as tablets of 15 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type vials of 30 mg. The parenteral dose should be adjusted to the patient's requirement and may be up to 30 mg. or more every six hours, intramuscularly or intravenously.

981 4/69

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TUSSIONEX SUSPENSION/TABLETS: Each teaspoonful (5 cc.) or tablet of TUSSIONEX contains 5 mg. hydrocodone (Warning: May be habit-forming) and 10 mg. phenyltoloxamine, both as cation exchange resin complexes of sulfonated polystyrene.

Class B narcotic — oral Rx where state laws permit.

INDICATIONS: Coughs associated with respiratory infections including chronic sinusitis, colds, influenza, bronchitis, and cough resulting from measles, pulmonary tuberculosis, bronchiectasis, and bronchogenic carcinoma.

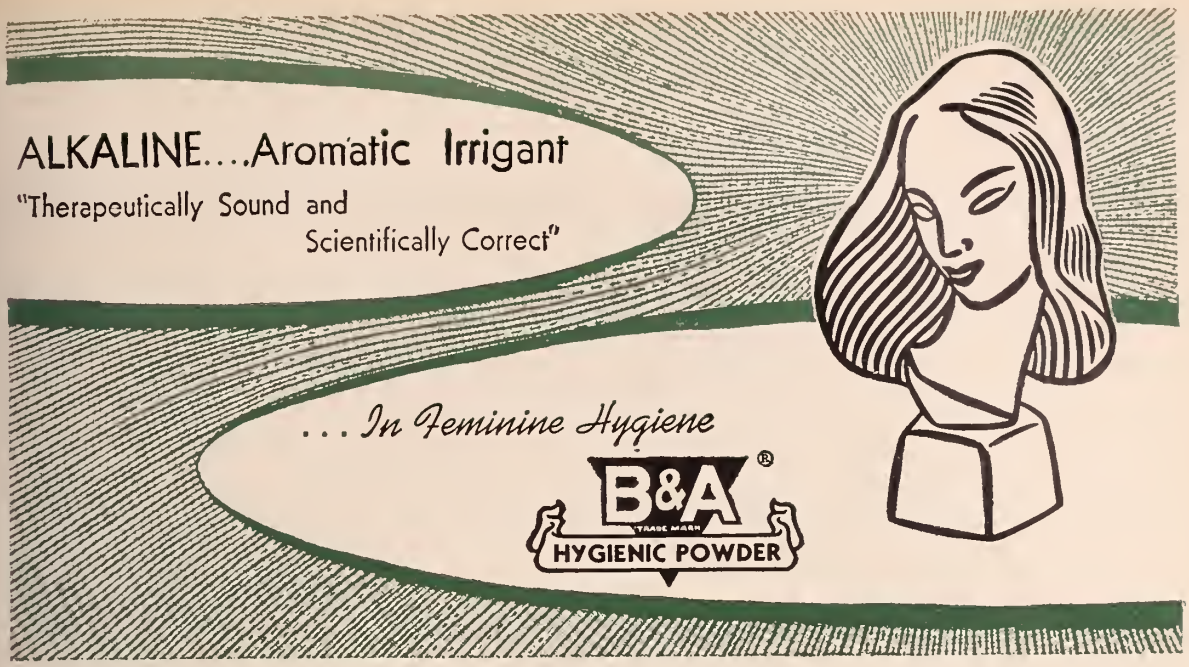
* DOSAGE: *Adults:* 1 teaspoonful (5 cc.) or tablet every 8-12 hours. *Children:* Under 1 year: 1/4 teaspoonful every 12 hours. From 1-5 years: 1/2 teaspoonful every 12 hours. Over 5 years: 1 teaspoonful every 12 hours.

SIDE EFFECTS: May include mild constipation, nausea, facial pruritus, or drowsiness.

For complete detailed information, refer to package insert or official brochure.

Strasenburgh

Strasenburgh Laboratories Division
Wallace & Tiernan Inc., Rochester, N. Y. 14623



"Early in 1953 Davis and Grand undertook a review of well established practices connected with the treatment of T. vaginalis infections. For instance, it had been accepted that an acid douche should be employed. This was based on cultural studies showing that when the pH was below 5 the organisms would die. They found that the commonly used vinegar douche with a pH of 3 showed no visible effect on T. vaginalis under the microscope in 15 minutes. Both citric and lactic acid were tested with similar results. Davis then recalled that in his early treatment of T. Vaginalis infections over 30 years ago he had had his first successes with alkaline preparations, and when he returned to their use the patients reported them more soothing than the previously used acid solutions."

(Am. J. Obst. & Gynec., 68:559, 1954)

Criteria for Cleansing Douche

"Daily douching often is a part of the treatment administered in dealing with T. vaginalis and since it is possible that the solution might contain agents that could hamper the regrowth of Doederlein bacillus, the following properties were said to be ideal.

1. It should contain a harmless, nonsensitizing detergent to remove mucous deposits and debris.
2. It should not contain any antibacterial agents, since the contact possible during douching would be so fleeting that anti-bacterial action could not be expected.
3. It should be acid in pH.

The 3rd property seems to be the most illogical and unimportant. If contact is so fleeting that antibacterial actions could not be expected, it would seem to follow that its acid quality would be of no consequence. Furthermore, acid solutions are irritating to the mucosa and oftentimes accentuate inflammation.

Actually, the value of a douche is generally conceded to be confined to its use as a cleansing and deodorizing agent. The encouraging results achieved with a detergent douche solution in treating infections of the vagina are probably attributable to the enormous normal recuperative powers of the vaginal tissues which have been under-estimated as a factor in the restoration of normal physiology.

Therefore, simple cleansing of the vagina with a non-irritating, mildly alkaline douche which is soothing to the vaginal mucosa and which penetrates and flushes out the dead organisms, debris and mucinous materials frequently enables the physiological processes to overcome the infection."

Charles B. Marek, M.D., Chief of Gynecology; Bon Secours Hospital: personal communications August 11, 1964

For physician samples write to:

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Eastern Research Laboratories, Inc. • 302 S. Central Ave. • Baltimore, Md. 21202


It takes more than a pi
to lose weight

That's why Abbott's got what it takes–
a pill and a program for each patient

THE PRODUCT–5 Different Strengths

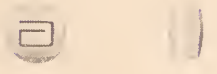
For smooth appetite control plus mood elevation

Desoxyn® Gradumet®
Methamphetamine Hydrochloride in Long-Release Dose Form

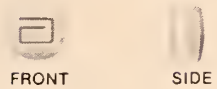


For patients who can't take plain amphetamine

Desbutal® 10 Gradumet
10 mg. Methamphetamine Hydrochloride, 60 mg. Sodium Pentobarbital



Desbutal 15 Gradumet
15 mg. Methamphetamine Hydrochloride, 90 mg. Sodium Pentobarbital



THE PROGRAM–3 Patient Booklets



Weight Control Booklet
Specifically written to help your patients understand why they are overweight, and what they can do about it. The booklet stresses the importance of *changing lifelong eating habits* and explains how this can be done, sensibly, comfortably —and permanently. Food exchanges and a comprehensive list of foods, showing their calories, are also included.



Food Diary
Designed to help the overweight patient follow your eating instructions. Space is provided for breakfast, lunch, supper, and even snacks. By writing down everything that's eaten each day, the patient is constantly reminded that she's trying to change her eating habits. And you are furnished with a written record of how well she's doing.



Picture Menu Booklet
Compact new booklet features appetizing lunch and dinner menus for every day of the week. The meals are depicted in full color and the correct portion size so that the dieter can see the amount of food that's recommended. Patients are pleasantly surprised to learn that each day's meals add up to only 1,000 calories.

902110

ABBOTT

Please see Brief Summary on next page.

Ask Your Abbott Man For Patient Supplies.

BRIEF SUMMARY

Desoxyn® Gradumet®

Methamphetamine Hydrochloride
in Long-Release Dose Form

Desbutal® 10 Gradumet

10 mg. Methamphetamine Hydrochloride,
60 mg. Sodium Pentobarbital

Desbutal 15 Gradumet

15 mg. Methamphetamine Hydrochloride,
90 mg. Sodium Pentobarbital

Indications: Desoxyn and Desbutal are used orally as appetite suppressants, for reduction of mild mental depression, and to help in management of psychosomatic complaints or neuroses. Desoxyn, when administered parenterally, may be used as a vasopressor agent or analeptic.

Contraindications: Methamphetamine (in Desoxyn and Desbutal) is contraindicated in patients taking a monoamine oxidase inhibitor. Do not use pentobarbital (in Desbutal) in persons hypersensitive to barbiturates, or in those with history of manifest or latent porphyria.

Precautions, Side Effects: Observe caution in patients with hypertension, cardiovascular disease, hyperthyroidism, old age, or those sensitive to sympathomimetic drugs. Prolonged usage may lead to tolerance or psychic dependence. Careful supervision is necessary to avoid chronic intoxication and drug dependence.

Amphetamine side effects such as headache, excitement, agitation, palpitation or cardiac arrhythmia usually may be controlled by reducing the dose. Paradoxically-induced depression is an indication to withdraw the drug. Because of its sodium pentobarbital content, use Desbutal with caution in patients receiving coumarin anticoagulants. Pentobarbital may cause skin rash. Nervousness or excessive sedation with Desbutal is often transient.

902110

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Idylease is the kind of convalescent home that puts patients at ease quickly.

And their physicians and families, too.

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An open staff with consultant specialist services on hand insures that the orders of private physicians are carefully followed by resident physicians with reports rendered frequently.

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Emphysema, Chronic Bronchitis and Asthma are relieved in fifteen minutes by the fast-disintegrating, uncoated Mudrane tablet.

Checkpoints:
DILATES THE BRONCHI
DRAINS THE MUCUS
SEDATES MILDLY
SUSTAINED ACTION
SUPERIOR TOLERANCE

Each tablet contains:

POTASSIUM IODIDE	195 mg.
AMINOPHYLLINE	130 mg.
PHENOBARBITAL, Caution: may be habit forming.	21 mg.
EPHEDRINE HCl	16 mg.

FEDERAL LAW PROHIBITS DISPENSING WITHOUT PRESCRIPTION

Precautions: Usual for aminophylline-ephedrine-phenobarbital. Iodides may cause nausea, long use may cause goiter. Discontinue if symptoms of iodism develop. Iodide contraindications: tuberculosis, pregnancy.

DOSAGE: One tablet, with full glass of water, 3 or 4 times daily.

Dispensed in bottles of 100 and 1000 tablets.

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RICHMOND, VIRGINIA 23217
Manufacturers of ethical pharmaceuticals since 1856

mudrane®

BRONCHIAL DISTRESS

no gag



DIA-QUEL actually tastes good

DIA-quel contains the only therapeutically active ingredient of paregoric—tincture of opium. This has been combined with homatropine methylbromide and pectin to make a sensible antidiarrheal formula.

By leaving out paregoric's outdated preservative—bitter-tasting camphor—we've produced an antidiarrheal that is good-tasting, as well as effective and prompt-acting in acute, nonspecific diarrheas and their accompanying "cramps." It is DIA-quel, a clear, red liquid with a pleasant cherry flavor.

Each teaspoonful (5 ml.) of DIA-quel Liquid contains:
Tincture of Opium... 0.03 ml.—Equivalent to 0.75 ml. of paregoric.
(Warning: May be habit forming)
To reduce hypermotility and frequency.
Homatropine Methylbromide... 0.15 mg.
A safe dose for mild spasmolysis to curb cramping and griping.
Pectin... 24. mg.
Demulcent, adsorbent. Helps form stools.
Alcohol 10% by volume.

In case you're curious, back in the 1700's paregoric was being used for diarrhea, but since the state of the pharmaceutical art was extremely primitive, fungus growth in the medication was a problem. Bitter-tasting camphor was added to prevent such growth and anise oil was added in an attempt to cover up the camphor taste. DIA-quel Liquid is a modern formulation that does not contain either of these outdated ingredients.

Caution: With use of DIA-quel Liquid observe the usual precautions associated with opium derivatives and anticholinergics.

Dosage: Usual adult dosage: 1 or 2 tablespoonfuls (15 or 30 ml.) t.i.d. or q.i.d. Usual children's dosage (Clark's rule): ½ to 2 teaspoonfuls (2.5 to 10 ml.) t.i.d. or q.i.d.

How Supplied: In 4 fl. oz. (118 ml.) band-sealed bottles.

DIA-quel is a Federally exempt narcotic (Class X) preparation. Where state law permits, no prescription is necessary.

For a complimentary sample of DIA-quel, simply mail your request to us on a signed prescription blank.

DIA-QUEL LIQUID

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INTERNATIONAL PHARMACEUTICAL CORP.
Warrington, Pennsylvania 18976

in the treatment of

IMPOTENCE



Android®

(thyroid-androgen) TABLETS

*Effectiveness confirmed by another double blind study**

1. SUMMARY

ANDROID	GOOD TO EXCELLENT 75%
PLACEBO	20%

2. Forty cases reported.
3. Cites synergism between androgen and thyroid.
4. No side effects in patients treated.
5. Alleviation of fatigue noted
6. Case histories on 4 patients.
7. Although psychotherapy still needed, role of chemotherapy cannot be disputed.

**"Sexual impotence treatment with methyl testosterone – thyroid (ANDROID) a double blind study" – Montesano, Evangelista: Clinical Medicine, April 1966.*

CONTRAINDICATIONS—Methyl testosterone is not to be used in malignancy of reproductive organs in male, coronary heart disease. Thyroid is not to be used in heart disease, hypertension unless the metabolic rate is low.

also available with ESTROGEN

Android-E

Each Tablet Contains:

Methyl Testosterone	2.5 mg.
Ethinyl Estradiol	0.02 mg.
Thyroid Ext. (1/6 gr.)	10 mg.
Thiamine Hydrochloride	10 mg.
Glutamic Acid	50 mg.

INDICATIONS: Advantage is taken of the anabolic action of ANDROID without its virilizing effect. Estrogen balances the androgen—only steroid effect remains. Geriatrics, post-operative and debilitating disease, osteoporosis. **DOSE**: One tablet t.i.d. Female patients should have a rest period 5 to 7 days after 21 days of medication. **SIDE EFFECTS**: In the female, excessive dosage may produce virilizing effects of most androgens: hoarseness, hirsutism, enlarged clitoris. Symptoms can be avoided by keeping the dosage below 300 mg. of testosterone per month. **CONTRA-INDICATIONS**: See Android. Ethinyl estradiol is not to be used in latent malignancy of reproductive organs or mammary glands.

Choice of 4 *strengths*

Android

Each yellow tablet contains:

Methyl Testosterone	2.5 mg.
Thyroid Ext. (1/6 gr.)	10 mg.
Glutamic Acid	50 mg.
Thiamine HCL	10 mg.

Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000.

Android-HP

HIGH POTENCY

Each red tablet contains:

Methyl Testosterone	5.0 mg.
Thyroid Ext. (½ gr.)	30 mg.
Glutamic Acid	50 mg.
Thiamine HCL	10 mg.

Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000.

Android-X

EXTRA HIGH POTENCY

Each orange tablet contains:

Methyl Testosterone	12.5 mg.
Thyroid Ext. (1 gr.)	64 mg.
Glutamic Acid	50 mg.
Thiamine HCL	10 mg.

Dose: 1 or 2 tablets daily.
Available:
Bottles of 60, 500.

REFER TO PDR

Android-Plus

WITH HIGH POTENCY B-COMPLEX AND VITAMIN C

Each white tablet contains:

Methyl Testosterone	2.5 mg.
Thyroid Ext. (¼ gr.)	15 mg.
Ascorbic Acid (Vit. C)	250 mg.
Thiamine HCL	25 mg.
Glutamic Acid	100 mg.
Pyridoxine HCL	5 mg.
Niacinamide	75 mg.
Calcium Pantothenate	10 mg.
Vitamin B-12	2.5 mcg.
Riboflavin	5 mg.

Dose: 2 tablet twice daily.
Available: Bottles of 60, 500.

Write for literature and samples:

BROWN THE BROWN PHARMACEUTICAL CO.
2500 W. 6th St., Los Angeles, Calif. 90057

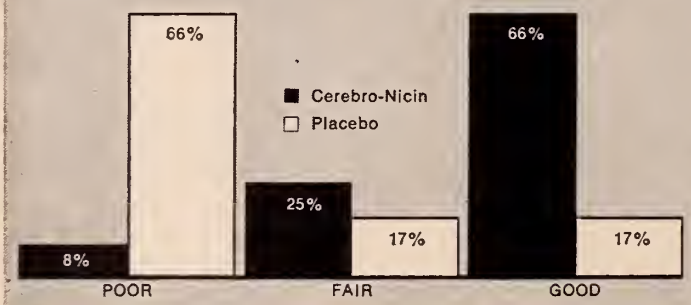
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apathy
irritability
forgetfulness
confusion

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capsules/elixir

A Gentle Cerebral Stimulant and Vasodilator



CEREBRO-NICIN® New double-blind study* shows how effectively senility can be forestalled. Four times as many aging patients showed striking improvement.

*A Double-Blind Study of Cerebro-Nicin, Therapy for the Geriatric Patient, R. Goldberg Jrnl,. of the Amer. Ger. Soc. June, 1964

Available in a tasty wine base elixir and capsules

Each Cerebro-Nicin capsule contains:

Pentylenetetrazole	100 mg.
Nicotinic Acid	100 mg.
Ascorbic Acid	100 mg.
Thiamine HCl	25 mg.
1-Glutamic Acid	50 mg.
Niacinamide	5 mg.
Riboflavin	2 mg.
Pyridoxine	3 mg.

DOSAGE: One capsule t.i.d. or as prescribed by physician.
AVAILABLE: Bottles of 100, 500, 1000 capsules.
Also elixir pint bottles.
CONTRAINDICATIONS: There are no known contraindications to Pentylenetetrazole although caution should be exercised when treating patients with a low convulsive threshold.
Most persons experience a flushing or tingling sensation after taking a highar potency niacin-containing compound. As a secondary reaction some will complain of nausea and other sensations of discomfort. This reaction is transient and is rarely a cause of discontinuance of the drug if the patient is forewarned to expect the reaction.

REFER TO PDR

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Write for Product Catalog

In the complex picture of moderate to severe anxiety...



there is a new reason for prescribing Mellaril (Thioridazine HCl)

effectiveness in mixed anxiety-depression

Long recognized for its usefulness in the treatment of moderate to severe anxiety, Mellaril is now also known to be effective against mixed anxiety-depression.

Often the symptoms of anxiety states are difficult to sort out—even with the most careful probing. The patient may manifest symptoms of agitation, restlessness, insomnia, somatic complaints. But what of the depression that may be mixed in the total picture? It is reassuring to know that Mellaril may be prescribed—with strong possibilities of success—when there is anxiety alone or a mixture of anxiety and depression.

Before prescribing or administering, see Sandoz literature for full product information, including adverse reactions reported with phenothiazines. The following is a brief precautionary statement.

Contraindications: Severe central nervous system depression, comatose states from any cause, hypertensive or hypotensive heart disease of extreme degree.

Warnings: Administer cautiously to patients who have previously exhibited a hypersensitivity reaction (e.g., blood dyscrasias, jaundice) to phenothiazines. Phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides. During pregnancy, administer only when necessary.

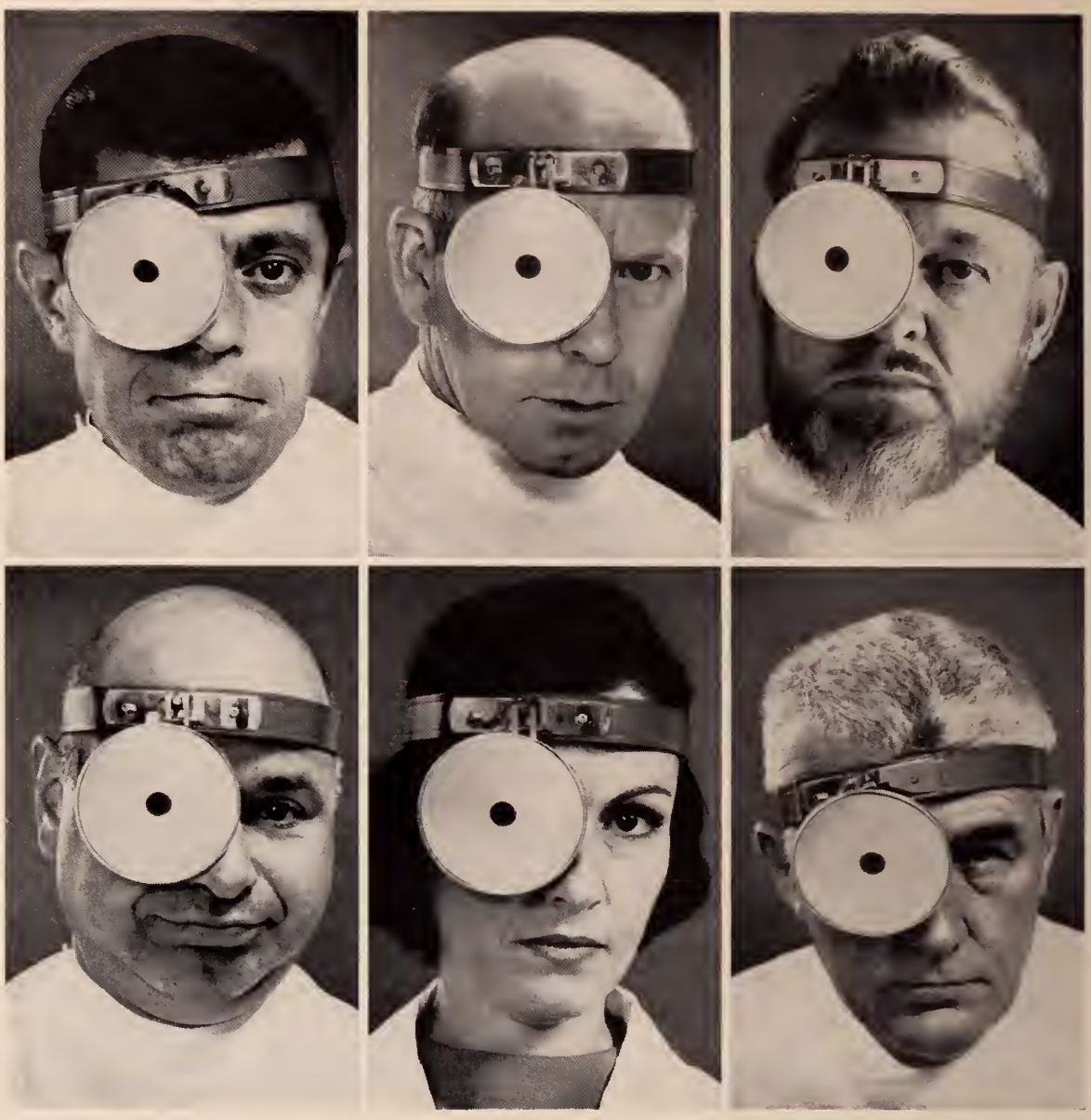
Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy may be avoided by remaining within the recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving). Orthostatic hypotension is more common in females than in males. Do not use epinephrine in treating drug-induced hypotension. Daily doses in excess of 300 mg. should be used only in severe neuropsychiatric conditions.

Adverse Reactions: *Central Nervous System*—Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomic Nervous System*—Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System*—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin*—Dermatitis and skin eruptions of the urticarial type, photosensitivity. *Cardiovascular System*—Changes in the terminal portion of the electrocardiogram have been observed in some patients receiving the phenothiazine tranquilizers, including Mellaril (thioridazine hydrochloride). While there is no evidence at present that these changes are in any way precursors of any significant disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients previously showing electrocardiographic changes. The use of periodic electrocardiograms has been proposed but would appear to be of questionable value as a predictive device. *Other*—A single case described as parotid swelling.

Mellaril®
(Thioridazine HCl) 25 mg. t.i.d.

for moderate to severe anxiety and mixed anxiety-depression

SANDOZ SANDOZ PHARMACEUTICALS, HANOVER, N. J. 68-170



"All Otolaryngologists are Alike"

Just look at them and you can see how much they have in common. Besides, they all go through pretty much the same training, and pass the same kinds of tests, and measure up to the same sort of standards. Therefore, all otolaryngologists are alike. Right?

Wrong! But that's no more preposterous than what some people say about aspirin. Namely: since all aspirin is at least supposed to come up to certain required standards, then all aspirin tablets must be alike.

Bayer's standards are far more exacting. In fact, there are at least nine *specific differences* involving moisture content, purity, potency and speed of tablet disintegration, which make the manufacture of Bayer® Aspirin so different.

These Bayer standards result in significant product benefits, including gentleness to the stomach and product stability, that enable Bayer Aspirin tablets to *stay* strong and gentle until they are taken.

So next time you hear someone say that a*ll* aspirin tablets are alike, you can say, with confidence, that "it just isn't so."

You might also say that all otolaryngologists aren't alike, either.







Nose clear as a whistle

(THANKS TO DIMETAPP®)

Dimetapp Extentabs® does an outstanding job of helping to clear up the stuffiness, drip and congestion of colds and upper respiratory allergies and infections. Each Extentab keeps working up to 12 hours. And for most patients drowsiness or overstimulation is unlikely. Try Dimetapp. It clearly works.

UP TO 12 HOURS CLEAR BREATHING ON ONE TABLET

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Dimetane® (brompheniramine maleate), 12 mg.; phenylephrine HCl, 15 mg.; phenylpropanolamine HCl, 15 mg.

FOR UPPER RESPIRATORY ALLERGIES AND INFECTIONS

Indications: Dimetapp is indicated for symptomatic relief of the allergic manifestations of respiratory illnesses, such as the common cold and bronchial asthma, seasonal allergies, sinusitis, rhinitis, conjunctivitis, and otitis.
Contraindications: Hypersensitivity to antihistamines. Not recommended for use during pregnancy.
Precautions: Until patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care to patients with cardiac or peripheral vascular diseases or hypertension.
Side Effects: Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia, have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered.
Dosage: 1 Extentab morning and evening.
Supplied: Bottles of 100 and 500.

A.H. ROBINS COMPANY
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Mild ulcerative colitis may be triggered here...



In mild ulcerative colitis, a number of factors can precipitate an attack: for instance, dietary indiscretion, such as eating raw foods, or emotional overreaction, such as that aroused by financial difficulties. No matter what causes the patient's sensitive colon to "act up," he soon suffers from acute discomfort...and often, from anxiety and apprehension as well. Such patients frequently respond well to adjunctive dual-action Librax® therapy.

Librax combines, in a single convenient capsule, the well-known antianxiety effect of Librium® (chlordiazepoxide HCl) and the dependable anticholinergic /antispasmodic effect of Quarzan® (clidinium Br). Therefore, as Librax helps to relieve the patient's excessive anxiety and reduce his overreaction to stress, it also, at the same time, helps to control hypersecretion and hypermotility, thus relieving spasm and abdominal discomfort.

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INDICATIONS: Indicated as adjunctive therapy to control emotional and somatic factors in gastrointestinal disorders.

CONTRAINDICATIONS: Patients with glaucoma; prostatic hypertrophy and benign bladder neck obstruction; known hypersensitivity to chlordiazepoxide HCl and/or clidinium bromide.

WARNINGS: Caution patients about possible combined effects with alcohol and other C depressants. As with all CNS-acting drugs, c tion patients against hazardous occupations quiring complete mental alertness (*e.g.*, opera machinery, driving). Though physical and p chological dependence have rarely been repo on recommended doses, use caution in ministering Librium (chlordiazepoxide hy chloride) to known addiction-prone individ or those who might increase dosage; withdra symptoms (including convulsions), follow discontinuation of the drug and similar to th seen with barbiturates, have been reported. of any drug in pregnancy, lactation, or in wor of childbearing age requires that its poten benefits be weighed against its possible haza As with all anticholinergic drugs, an inhibi effect on lactation may occur.

PRECAUTIONS: In elderly and debilita limit dosage to smallest effective amount to p clude development of ataxia, oversedation confusion (not more than two capsules per initially; increase gradually as needed and to

or here.



d). Though generally not recommended, if nbination therapy with other psychotropics ms indicated, carefully consider individual ırmacologic effects, particularly in use of po- tiating drugs such as MAO inhibitors and :nothiazines. Observe usual precautions in sence of impaired renal or hepatic function. adoxical reactions (*e.g.*, excitement, stimula- ı and acute rage) have been reported in psy- atric patients. Employ usual precautions in ıtment of anxiety states with evidence of im- ding depression; suicidal tendencies may be sent and protective measures necessary. Vari- e effects on blood coagulation have been orted very rarely in patients receiving the g and oral anticoagulants; causal relation-) has not been established clinically.

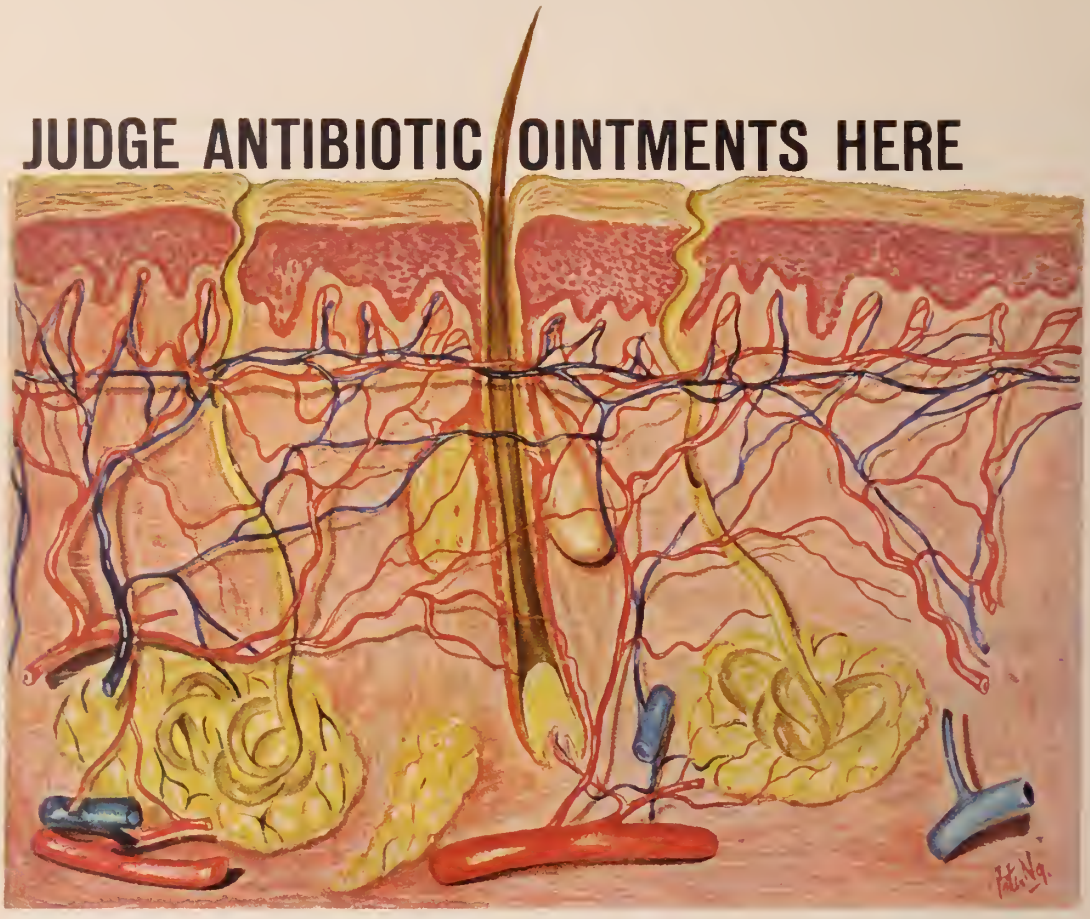
DVERSE REACTIONS: No side effects or ıifestations not seen with either compound ıe have been reported with Librax. When ordiazepoxide hydrochloride is used alone, wsiness, ataxia and confusion may occur, cially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally with chlordiazepoxide hydrochloride, making periodic blood counts and liver-function tests advisable during protracted therapy. Adverse effects reported with Librax are typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy and constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diet.

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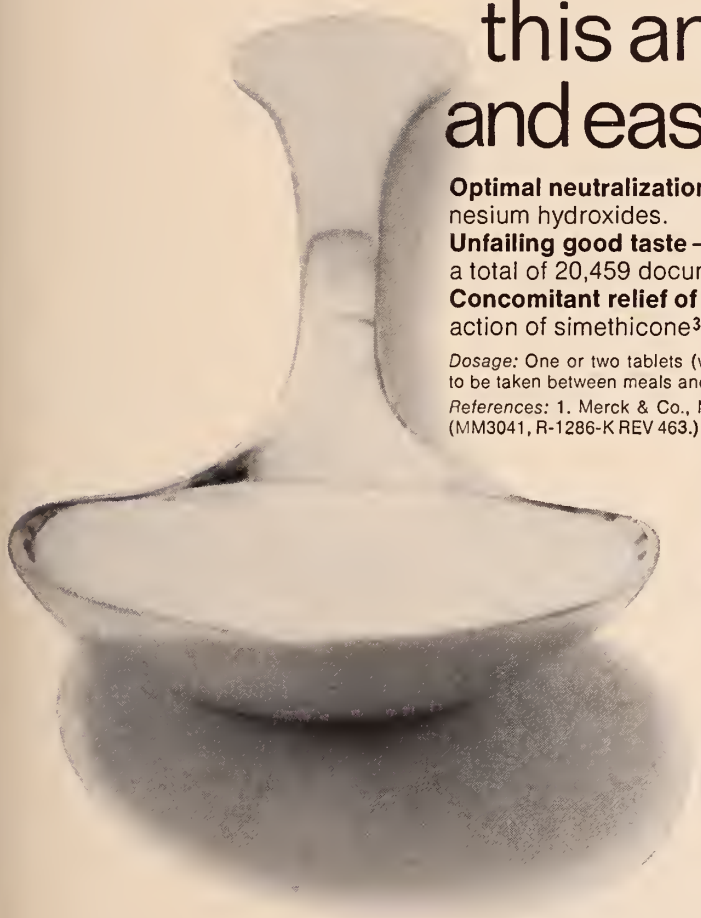
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References: 1. Merck & Co., Merck Chemical Division: Antacid Literature Survey, Rahway, New Jersey. (MM3041, R-1286-K REV 463.) 2. Danhof, I.E., report on file. 3. Hoon, J.R.: Arch. Surg. 93:467 (Sept.) 1966.

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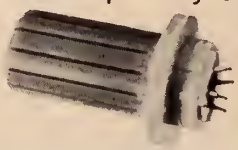
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Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms have occurred following abrupt discontinuance. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

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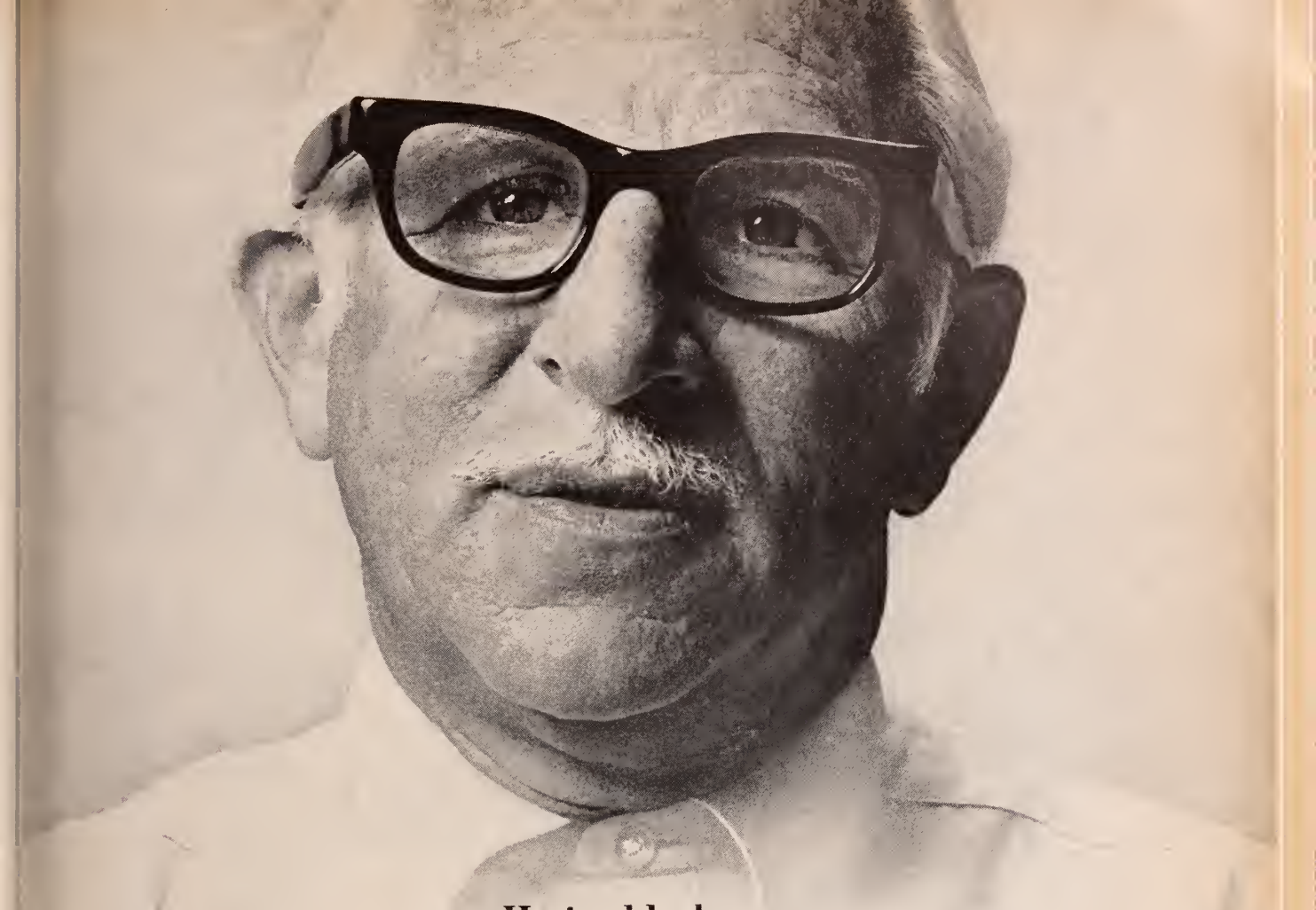
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Demethylchlortetracycline HCl 300 mg
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Contraindication: History of hypersensitivity to demethylchlortetracycline or nystatin.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

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Indications: Infections of respiratory, gastrointestinal and genitourinary tracts and skin and soft tissues due to tetracycline-sensitive organisms, in patients with increased susceptibility to monilial infections.

Contraindications: The drug is contraindicated in patients hypersensitive to its components.

Warnings: Photodynamic reactions have been produced by tetracyclines. Natural and artificial sunlight should be avoided during therapy. Stop treatment if skin discomfort occurs. With renal impairment, systemic accumulation and hepatotoxicity may occur. In this situation, lower doses should be used. Tooth staining and enamel hypoplasia may be induced during tooth development (last trimester of pregnancy, neonatal period and childhood).

Precautions: Bacterial superinfections may occur. Infants may develop increased intracranial pressure with bulging fontanels. In gonorrheal therapy, serologic tests for syphilis should be conducted initially and monthly for 3 months.

Adverse Reactions: Glossitis, stomatitis, nausea, diarrhea, flatulence, proctitis, vaginitis, dermatitis, and allergic reactions may occur.

Usual Adult Dosage: 1 capsule q.i.d. Continue for 10 days in Beta-hemolytic streptococcal infections. Administer one hour before or two hours after meals.

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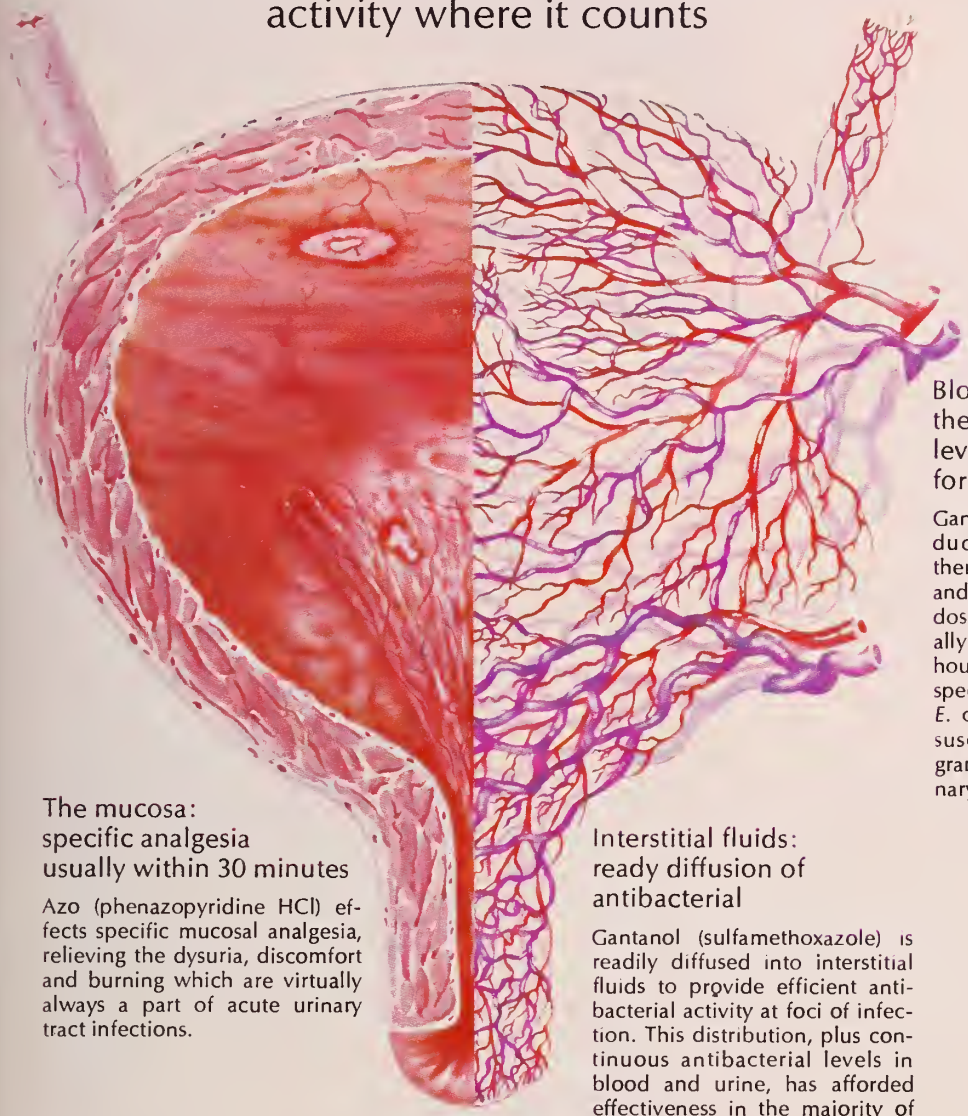
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Contraindicated in sulfonamide-sensitive patients, pregnant females at term, premature infants, newborn infants during the first three months of life, glomerular nephritis, severe hepatitis, uremia and pyelonephritis of pregnancy with gastrointestinal disturbances.

Warnings: Use only after critical appraisal in patients with liver damage, renal damage, urinary obstruction or blood dyscrasias. If toxic or hypersensitivity reactions or blood dyscrasias occur, discontinue therapy. In intermittent or prolonged therapy, blood counts and liver and kidney function tests should be performed.

Precautions: Observe usual sulfonamide therapy precautions including maintenance of an adequate fluid intake. Use with caution in patients with histories of allergies and/or asthma. Patients with impaired renal function should be followed closely since renal impairment may cause excessive drug accumulation. Occasional failures may occur due to resistant microorganisms. Not effective in virus and rickettsial infections.

Adverse Reactions: Headache, nausea, vomiting, urticaria, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, skin rash, Stevens-Johnson syndrome, injection of the conjunctiva and sclera, petechiae, purpura, hematuria or crystalluria may occur, in which case the dosage should be decreased or the drug withdrawn.

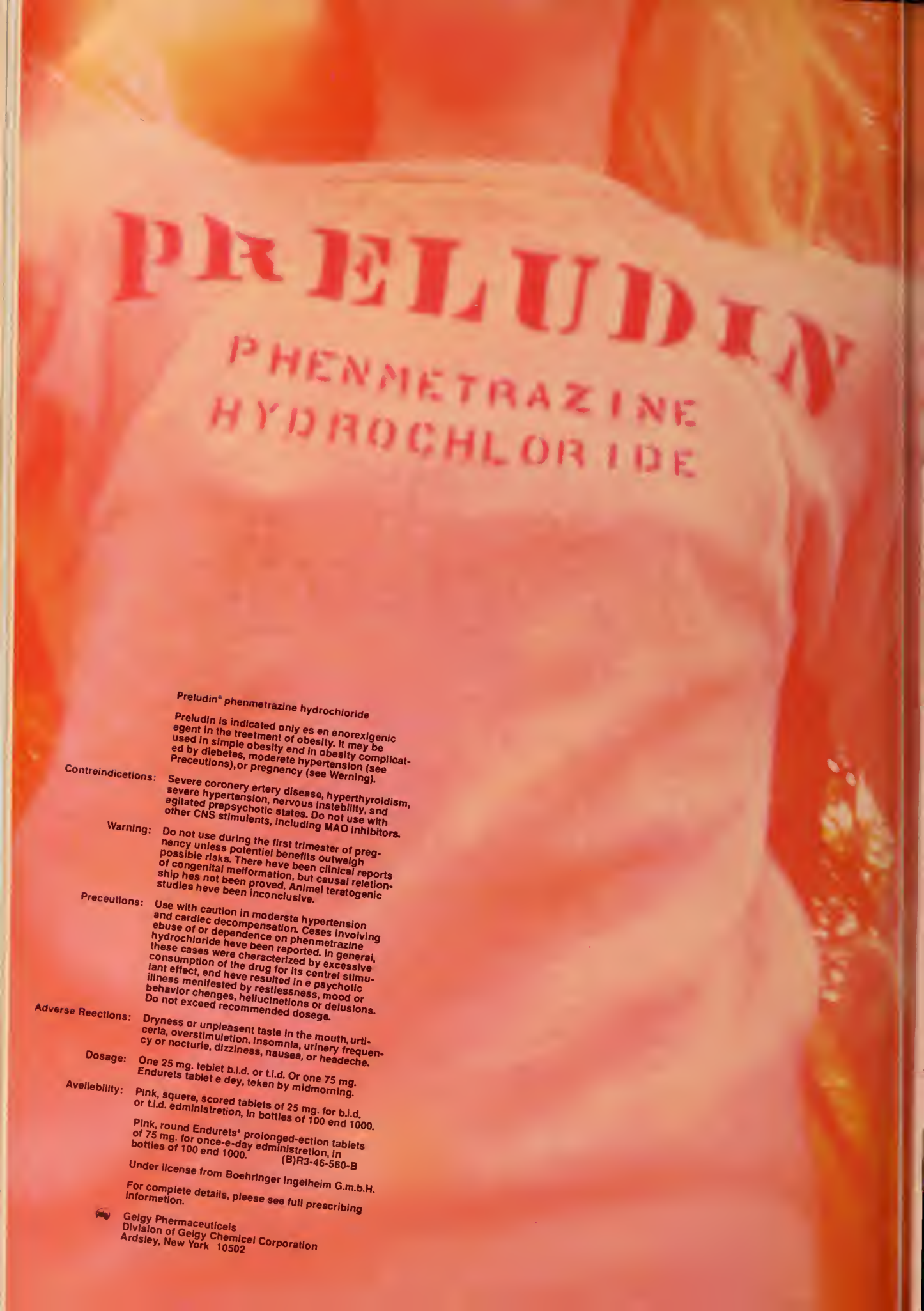
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Warning: Do not use during the first trimester of pregnancy unless potential benefits outweigh possible risks. There have been clinical reports of congenital malformation, but causal relationship has not been proved. Animal teratogenic studies have been inconclusive.

Precautions: Use with caution in moderate hypertension and cardiac decompensation. Cases involving abuse of or dependence on phenmetrazine hydrochloride have been reported. In general, these cases were characterized by excessive consumption of the drug for its central stimulant effect, and have resulted in a psychotic illness manifested by restlessness, mood or behavior changes, hallucinations or delusions. Do not exceed recommended dosage.

Adverse Reactions: Dryness or unpleasant taste in the mouth, urticaria, overstimulation, insomnia, urinary frequency or nocturia, dizziness, nausea, or headache.

Dosage: One 25 mg. tablet b.i.d. or t.i.d. Or one 75 mg. Endurets tablet a day, taken by midmorning.

Availability: Pink, square, scored tablets of 25 mg. for b.i.d. or t.i.d. administration, in bottles of 100 and 1000.

Pink, round Endurets® prolonged-action tablets of 75 mg. for once-a-day administration, in bottles of 100 and 1000. (B)R3-46-560-B

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For complete details, please see full prescribing information.

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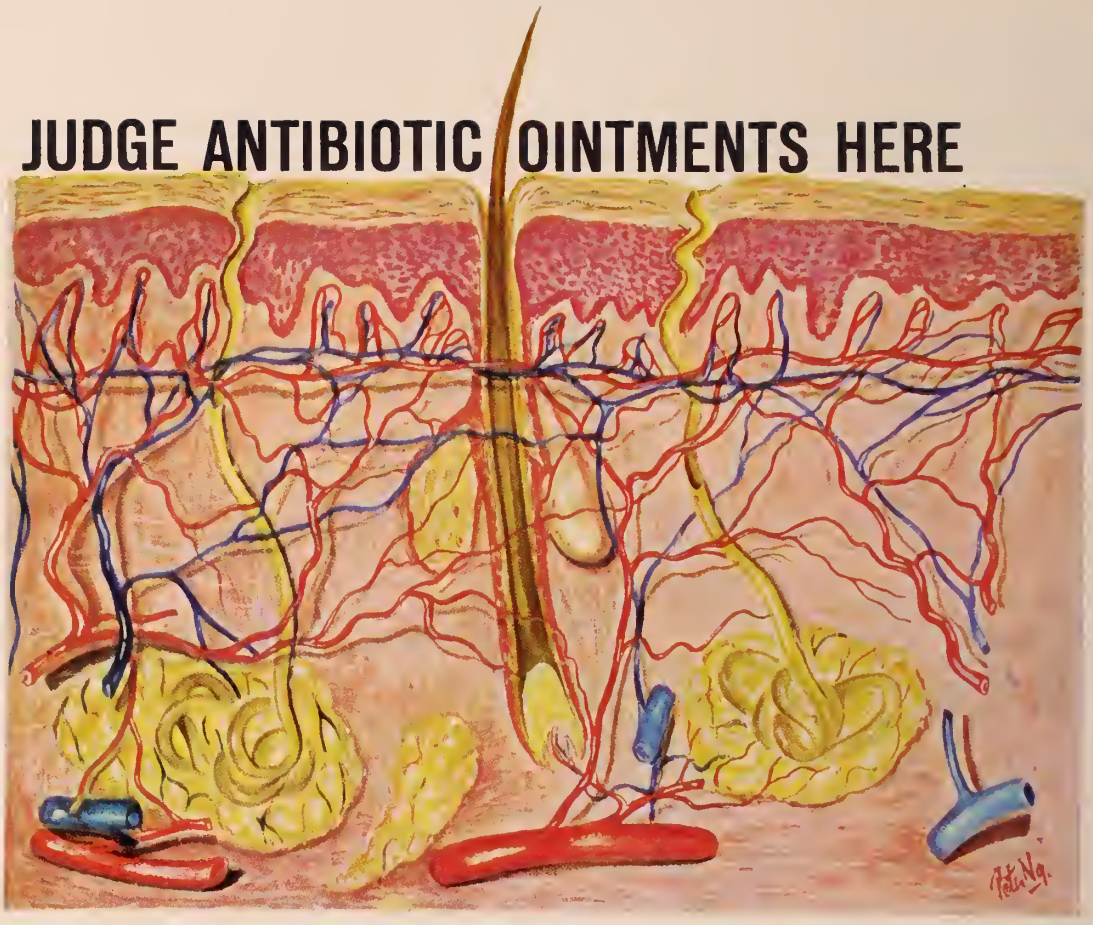
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A few patients may experience overstimulation or insomnia. For a brief summary of all adverse reactions, precautions, warning and contraindications, please see the adjoining page.

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Endurets® prolonged-action tablets

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REFERENCES: (1) Sands, R.X.: New York St. J. Med. 61:2598-2602, 1961; (2) Renner, M.J., et al.: Hosp. Topics 39:71-73, 1961; (3) Haas, Jr., J., and Kay, L. L.: Southwest Med. 42:30-32,1961; (4) Marshall, W.: Clin. Med. 7:499-502, 1960; (5) Strauss B.: Clin. Med. 4:307-310, 1957.

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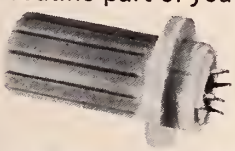
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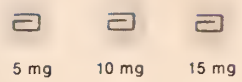

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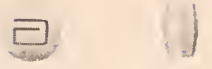
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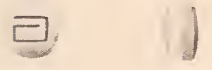


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EDITORIALS

The Hazards Of Counseling

It is unusual for a medical man to describe what he is doing as "counseling." We have, in the past few decades, developed several counseling professions outside of medicine, so that the verb now has a decidedly non-clinical flavor. Thus, counseling psychologists command good salaries and much prestige. In the vocational guidance field, there has been a subspecialty known as vocational counseling. This is different from, though related to, rehabilitation counseling. In the yellow pages of big city phone books you will find a special listing for marriage counselors. Some clergymen like to be called pastoral counselors. And let us say nothing about investment counselors, counselors-at-law or tax counselors.

Because of the shrinkage of the physician's nonclinical advice-giving function, he is not likely to get into many difficulties here. However, some doctors give erroneous advice about adoption procedures, not realizing how tightly this is regulated by law. Some physicians advise veterans about the service-connection of their illnesses when they do not know the VA's definitions of service connection or the processing of such claims. Medical practitioners sometimes give misinformation about whether certain disabilities are covered under health or accident policies. This bad advice doesn't cause invalidism but it certainly causes hard feelings. We know one situation where following an industrial accident, a doctor advised the victim that his disability flowed directly out of the accident — which was not legally true. The physician identified strongly with the patient, and wanted to believe it; and under this kind of pressure the patient slowly became more and more invalided. Held before his eyes was the glittering hope of a substantial monetary award when the case reached trial; and a conviction that the more disabled he was, the larger the money judgement. Here, the well-meant, ill-informed advice, might have led to invalidism.

We remember Mrs. A, who was told that the best thing for their family problem would be to have a baby. So she allowed herself to become pregnant and was delivered of a healthy baby. But far from soothing the troubled waters this arrival only complicated them. One wonders how unsophisticated that doctor was to have given so glib a prescription with so little understanding of, or sensitivity to, the family's real problem.

Then there was Mrs. B who married on the advice of the family physician. This doctor believed that what every troubled young woman needed was an active sex life. He cavalierly handed out that advice without realizing how futile it was in this case. In both examples, we see the physician trying to play God, yet denying that he had any such purpose. Several generations ago this might have worked well because the fact that he gave his blessing to a procedure practically guaranteed its success. With the current generation, however, it doesn't work that way.

Then, too, consider, Mr. C, a hypertensive cardiac. Some well-known cardiologists believe in getting their patients to do exercise and keep moving. Many, however, are more conservative, and keep the patient at bed-rest for long periods of time. Maybe the rest *is* indicated. We don't know. But we do know that enforced bed rest may produce excessive anxiety. All medical practitioners today know the vicious cycle of hypertension. Tell the patient he has high blood pressure, and the worry elevates his pressure still more. Then when you take the reading at the next visit, whistle as the mercury column rises. This worries him still more and so on and on the merry-go-round turns. This Mr. C, for instance, the one whose doctor enforced bed rest on him and who thus added to his anxiety, pushed up his blood pressure and increased his heart rate. Eventually Mr. C got over the heart attack so far as the myocardium was concerned. But now he won't even walk *down* a flight of stairs and he pampers himself so much that he has bleached all the joy out of life.

Logically, we are on the horns of a dilemma here. If we do *not* give specific suggestions, we are charged with failing the patient when he depends on us. But if we *do* hand out neat capsules of advice, we are told that we are playing God. The trick is somehow to make the suggestions without sounding as if we're talking from Mt. Olympus, to admit our imperfections, to confess that there is a lot we don't know, and perhaps to think twice before we speak once.

Who Are The Most Patient Patients?

Men may make the best husbands, but according to some researchers, women make the best patients. Ask any nurse. Being, by nature, suspicious of women, and preferring—also by nature—the company of men, the average woman nurse might be expected to prefer male patients just as other women workers prefer male bosses and male customers. But, though they say it reluctantly, they join their sisters in asserting that in a sick-bed, a man is just a little boy grown-up. Not so grown up, either. In their patient rating scale, males apparently don't rate so well.

The real test of a patient's patience, however, is the dental chair. Here a patient, no matter how calm he pretends to be, signals his tension by slight psychomotor movements which the dentist can detect. And, according to a dental survey made, appropriately, by *Dental Survey*, women make better dental patients than men. As a matter of fact they also take better care of their teeth generally. It seems that in pre-adolescence, little boys consider any type of washing—whether in the mouth or behind the ears—a feminine frill. Worse than that, they believe that a defiance of mother's instructions to wash the teeth, is a symbol of manliness. Then through certain psychiatric mechanisms, not to be disclosed in this family periodical, the growing boy carries this low opinion of dental hygiene right into adult life. The adolescent may slick down his hair and clean his finger-nails while preparing for a date; but he apparently feels no need for washing in places where the fruit of his industry is not so visible. To the girl, on the other hand, cleanliness and body care seem to be basic virtues. All of which may account for the fact that women *are* better patients than men. Or are they?

The Physician As An Encourager Of Cigarette Smoking

As an apostle of health, the cigarette smoking physician is, indeed, in a paradoxical position. All doctors agree that cigarette smoking is a health hazard. About two-thirds of previously smoking physicians have abandoned it. The other third have developed some remarkable rationalizations, such as: (a) you have to die sometime anyway, or (b) the proof consists of mere statistics, or (c) my grandfather's brother lived to be 100 years old, even though he smoked since the age of 14, or (d) I know a 70 year old woman who died of a carcinoma of the lung although she never smoked, or (e) I'm hooked, so let's laugh it off!

At its December 1968 meeting, our AMA House of Delegates resolved that, "The AMA again urge its members to play a major role against cigarette smoking." And later, a resolution was passed to the effect that, "the AMA must take a firm stand against smoking by every means at its command."

Every time a physician, in the presence of a patient, puffs on a cigarette he is supporting the "do as I say, not as I do" thesis. He becomes permissive, by example, of a notorious health-destructive hazard. It may be possible to gloss it over by a flip comment or by a clownish joke, but the fact remains that he is encouraging a menace to human health. The AMA knows it, the public knows it, and the cigarette smoking doctor knows it.

ORIGINAL ARTICLES

A new concept of a team approach to provide comprehensive care for "stroke" victims is here outlined.

Transient Cerebral Ischemic Attacks*

E. Jefferson Browder, M.D., Ann A. Browder, M.D., and Alvin A. Florin, M.D./East Orange

Transient ischemic attacks are the clinical manifestations (due to functional derangement of the brain) consequent to transitory deficiency of arterial blood in a part or the whole of the brain. The most frequently encountered cause for this type of dysfunction is atherosclerosis of the extracranial cerebral arteries. Atheromatous lesions may produce stenosis or occlusion of one or more of these four great cervical arteries, thereby compromising blood flow to the brain. The resultant ischemic attack is variable but usually repetitive and with patterns indicating the area of the brain being deprived of its normal blood supply.

Investigations of malfunctions secondary to decreased perfusion of arterial blood in the brain have disclosed many important facts not yet in broad clinical trial. In striking contrast to this lag in the transfer of scientific knowledge into patient care is the experience with coronary artery disease. In this area, pathophysiologic information, derived from both animal experimentation and observation of patients with stenotic and occlusive disease of the coronary arteries, has been converted into medical and surgical corrective measures. Technics developed for the care of patients with cardiac infarction and the attending alterations in the conduction system of the heart are no longer limited to the great medical centers.[1] At the present rate of development of coronary care units, even in the smaller hospitals, this type of service will soon be locally available to many Americans.

The medical picture relative to the patients with atherosclerosis of the arteries supplying the brain and the complications arising therefrom is not so bright. The marked disability of those surviving a completed stroke is well known. Most restorative technics applied after a stroke fall far short of satisfactory rehabilitation in many instances. In effect, treatment after the stroke is no more than picking up the pieces of a major catastrophe and endeavoring to make the most of a calamitous situation. Frequently the family of the patient, their doctor, and often the patient himself regard stroke as a component of slow death. After receiving many therapeutic measures, repeated psychologic boosts, and the passing of time, all those involved, especially the patient, accept the disability and attempt to adjust to a different life.

This gloomy prognosis obtains today, despite a half century of clinical, experimental, and pathological observations. In 1914, Hunt[2] set forth the causal relationship between the stenotic and occlusive diseases of the aortocerebral arteries and cerebral infarction. During the ensuing four decades, and with increasing frequency, clinical and pathologic studies concerning the effects of atheromatous lesions of the extracranial cerebral arteries have been recorded in the literature. It eventually became recognized in sophisticated medical circles that varying degrees of athero-

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matous narrowing of the great arteries of the neck, supplying the brain, was a relatively common cause of stroke. It also became evident that transitory symptoms indicating cerebral dysfunction (the so-called transitory ischemic attacks) were not infrequently the forerunners of cerebral infarction. Finally, it was appreciated that narrowing or occlusion of the extracranial vessels rather than intracranial ones was the more frequent cause of transient ischemic attacks.

Recognizing the implications of these observations, DeBakey[3] in 1953 undertook to correct surgically atheromatous obstructions in the aortocranial arteries. Obstructed blood vessels were opened or extensively diseased portions bypassed by synthetic arterial grafts. Since then, favorable reports emanating from the Houston Clinic have appeared in the medical literature in numerous articles. In 1966 from Texas (pop. 9,579,677) 672 operations "on the carotids" were reported.[4] These 672 operations were performed in 44 widely scattered institutions in Texas. It seems likely that the designation "on the carotids" was used as an all-inclusive one for operations on the extracranial cerebral arteries in the upper mediastinal region as well as in the neck. In this same year (1966) there were a total of 147 such procedures in New Jersey (pop. 6,066,788) and 331 from the State of New York (pop. 16,782,304).[4] This represents a beginning. However, there are an estimated 4500 to 5000 patients a year in New Jersey with transient cerebral ischemia alone, not including "permanent stroke," in need of definitive diagnostic and therapeutic consideration. It is becoming more evident that surgical therapy for stenotic and occlusive atheromatous diseases of the aortocranial arteries is effective treatment for patients with transient ischemic attacks. Not only may the attacks be brought under control, but, more significantly, a probable completed stroke may be prevented.

Pathophysiological Considerations

An understanding of the anatomy of the arteries supplying the brain and the location of their pathologic lesions is prerequisite for the interpretation of symptoms associated with an impaired blood flow to the brain. Atherosclerosis is found in all anatomic segments of the extracranial cerebral vessels. However, the commonest site (for stenotic and occlusive lesions) is at the origin of the internal carotid artery, the carotid sinus segment. More frequently than formerly believed, the distal internal carotid may be occluded, especially if there is propagation of a thrombus from the level of carotid bifurcation up to the ophthalmic artery. When the occlusive lesion or lesions are sufficiently extensive to impair cerebral blood flow, cerebral insufficiency often results. This is clinically manifested by recurring attacks of numbness and/or weakness of one-half of the body, dizziness, confusion, headache, temporary blindness in one eye, and, at times, slurred speech.

The vertebral arteries are often diseased in a comparable manner in their proximal segments, more rarely in their course through the vertebral foramina, and sometimes in their intracranial segments. The resultant symptomatology, produced by reduction of blood flow to the hindbrain, midbrain, and the occipital lobes, is frequently characterized by intermittent numbness of the mouth and lips, transitory loss of balance, diplopia, and visual deficits. Other neurologic manifestations include dizziness, short-term hemiparesis, dysphasia, headache, confusion, and, in some, unconsciousness. Another vertebral basilar symptom-complex, the result of transitory hypoxia in the domain of the areas perfused by the vertebral arteries, has been appropriately termed the subclavian steal syndrome. In this condition, there is a stenotic or occlusive lesion of a subclavian artery proximal to the vertebral branch which results in the shunting of blood to an hypoxic upper extremity by way of the proximal basilar artery, thereby reducing the supply to the hindbrain.

Atheromatous lesions are also encountered in the aortocranial arteries: plaques protruding into the lumen of the artery, calcific masses, ulcerated intima surmounted by clot, intramural hemorrhage, or a combination of two or more of these. In any of these circum-

stances the pathologic narrowing of the lumen of an artery may compromise blood flow to the brain. Intimal ulcerations may, in addition, provide a source of small emboli to the brain, or a thrombus may break from its mooring and occlude a major cerebral vessel. If only one of the four extra-cranial cerebral arteries is occluded and the other arteries are relatively free of disease, cerebral function may not be impaired, since compensatory circulation is established through the collaterals of the Circle of Willis. This implies that cerebral insufficiency is usually associated with some implication of all extracranial cerebral arteries with one artery maximally involved by the atheromatous process.

Evaluation of the Patient

The objective is to identify the patient who has transient cerebral ischemic attacks as his outstanding difficulty. Those over 65 years of age form the largest group with atherosclerosis and frequently have symptoms indicating dysfunction not only of the brain, but also of the heart, kidneys, or lower extremities. A few pointed questions usually give the examiner a productive lead regarding the areas of disturbed function and an impression as to the patient who may be salvaged. Is the heart involved to an extent that there is shortness of breath on exertion? Has there been increasing nocturia? Is there intermittent claudication upon walking short distances? These or comparable simple inquiries may be amplified according to the patient's symptomatology.

Armed with an adequate history, a more intelligent systemic examination may be carried out. In particular, the status of the retinal arteries should be observed, *auscultation of the head and neck for bruit should be carefully performed,* estimation of the equality of the radial pulses made, and the pressure or absence of pulsations in the arteries of the lower extremities determined. A detailed neurologic examination may at times be desirable; however, deficits related to brain dysfunction are usually recognized easily by both the patient's family and the examiner. The urine should be analyzed with particular reference to specific gravity, excessive proteins, and sediment.

Collection of these data neither requires special knowledge on the part of the practitioner nor is it time-consuming. From this information an acceptable evaluation may be made covering cardiac function, renal efficiency, the status of arterial flow in the lower extremities, and the presence or absence of gross cerebral dysfunction both intermittent and enduring. While it may be satisfying to the family physician to be knowledgeable regarding oxygen transport and its utilization by the brain, the effects of metabolities, carbon dioxide accumulation, and pH shifts, this information is not essential for an understanding that transient ischemic attacks are a manifestation of decreased blood flow to a part of the brain. Furthermore, it is not necessary to depend on philosophical concepts such as cerebral arterial spasm or episodic vascular insufficiency secondary to decreased cardiac output, to explain the pathophysiologic mechanism of these attacks. It is most important, however, to recognize that these warning episodes frequently signal intermittent decrease in blood flow to the brain which may be followed by gross cerebral dysfunction.

If indicated, additional examinations may be done on an ambulatory basis: electrocardigrams, chemical analysis of the blood, x-rays of the head and thorax, and repeated blood pressure estimations. In the instances in which the principal concern is transient ischemic attacks and no gross circulatory abnormalities are disclosed in the heart, kidneys, or lower extremities, *the patient should be referred for consultation to a vascular or neurologic surgeon or to a neurologist.* Whenever the clinical features suggest a lesion in the extracranial cerebral arteries, the consultant should give serious consideration to complete four vessel cerebral arteriography.

Surgical Therapy

Since multiple involvement by atherosclerosis of the extracranial cerebral arterial system is

the rule, all principal sites of stenosis or occlusion must be clearly visualized on the arteriogram. These are:

1. Proximal internal carotids.
2. Vertebrals near their origin from the subclavians.
3. Innominate, carotid, and subclavian arteries usually near their origins.

Although some dangers are associated with this special examination, these are minimal compared to the potential dangers associated with an attitude of watchful waiting.[5-6] After complete diagnostic consideration, the problems involved and the proposed therapy should be clearly explained to the patient and his family. The extent of the arterial reconstruction necessary for a functional result will depend on the lesion in the involved artery or arteries and the general physical status of the patient. To resolve the patient's problem, more than one surgical procedure may be necessary. It is obvious that the surgeon assuming the responsibilities for surgical treatment must be knowledgeable regarding the many complications arising from cerebrovascular diseases. As surgical technics improve, operations on intracranial vessels and the segments of extra-cranial cerebral arteries now considered surgically inaccessible may become routine procedures.

Non-Surgical Therapies

A variety of non-surgical therapies have been used in an attempt to alter the clinical course in patients with stenotic or occlusive disease of extra-cranial cerebral arteries. Anticoagulants, carbon dioxide inhalation therapy, block of the stellate ganglion, thrombolytic substances, and vasodilators are some of the therapies that have received clinical trials. Anticoagulant therapy has been found reasonably effective in some patients with transitory ischemic attacks. This is long-term treatment and in many instances causes the doctor much anxiety since the patient frequently fails to follow specific advice as to appropriate prothrombin determinations. The benefits derived from anticoagulant therapy are often more than offset by hemorrhagic complications, some fatal.

The Scope of the Problem

In 1966, there were listed in the New Jersey Health Statistics[7] 5,096 deaths due to stroke, 2,890 from cerebral hemorrhage, 2,206 from cerebral thrombosis and embolism, and 548 deaths from ill-defined vascular lesions affecting the central nervous system. The estimated death rate for "acute stroke" in the United States is between 28 and 33 per cent. This combines the high mortality for intracranial hemorrhage with the lower death rate following stenotic or occlusive disease. Projecting these data, there must be in New Jersey 18,000 to 19,000 individuals a year who have, from one cause or another, the catastrophic episode termed "stroke." It is also evident that the majority of patients considered to have cerebral thrombosis have occlusion of extracranial artery or arteries as the causative factor for stroke. A conservative estimate of those with so-called cerebral thrombosis each year in New Jersey would be 8,000 of whom at least 4,500 to 5,000 have extra-cranial lesions. Therefore, minimally 3,500 to 4,000 patients a year in New Jersey have stroke preceded by transient ischemic attacks. Since only 147 operations "on the carotid" were performed in the State during 1966, the inference is that this procedure should be evaluated as a neglected preventive measure.

Comprehensive Care

There remains much to be done to improve the therapies for patients with cerebrovascular diseases. At the present time, as in the past, accent is on maximum restorative measures for patients with completed stroke. This is a necessary and credible endeavor and continued effort should be made to improve these services. There is disparity between current knowledge of cerebrovascular diseases and the medical approach usually employed. Transient cerebral ischemic attacks represent dysfunction of the brain but too often appropriate consideration is not given to available therapeutic measures to relieve the impediment of blood flow to the brain. The import of transient ischemic attacks and the magnitude of the problem involved should become common knowledge to those delivering health

services. Diagnostic and therapeutic facilities must be established for modern care of these patients. This should be coordinated with the intensive care of those critically ill with acute stroke, including constant-care units with modern apparatus for physiological monitoring to accord the patient optimal chance for survival. With what we now know about the cause and natural history of stroke, the surgical correction of inadequate cerebral blood flow heralded by transient ischemic attacks is one of the most promising areas for prevention of completed stroke.

The vigorous approach to transient ischemic attacks is not, of course, the entire solution to the problem of stroke. The unmet needs of many of the estimated 18,000 to 19,000 patients a year with stroke in New Jersey require a coordinated program: prevention, intensive care of acute stroke, and rehabilitation. The questions are as obvious as they are disturbing. How many of those with completed stroke could have been restored to normal or near normal states by surgical intervention performed shortly after onset of hemiplegia? How many during the acute phase of this catastrophic event received modern care in a constant-care unit? How many in need of restorative therapies ever had the facilities of a modern rehabilitation department available to them? There is no short cut to a proper resolution of the difficulties posed by patients with impaired blood supply to the brain. The Task Force Committees for Stroke of the New Jersey Regional Medical Program have made recommendations which, when implemented, will attempt to improve the situation. Specifically, the Task Force Committees have proposed that 8 or 10 comprehensive "stroke units" be established within the State. It has been suggested by the members of these committees that these units should be hospital-based and in an institution of sufficient size to have as members of the unit representatives from neurology, internal medicine (cardiology), vascular surgery, neurological surgery, and psychiatry. Such units would be available to patients with all phases of cerebrovascular diseases, from transient ischemic attacks through terminal rehabilitation.

In association with this service an educational program for each unit should be instituted: open-clinics, including seminars and conferences, for practicing physicians and allied health personnel of the region in which the stroke unit is functioning. After the unit has become operational in all its components, the message of modern care of the patient with pre-stroke, stroke, and post-stroke syndromes should be carried by all available media to the public. Success of a stroke team will necessitate the cooperation of the personnel of all health institutions of the region in which the stroke unit is located.

New medical advances will add to the armamentarium, but the responsibility is here now to make more effective application of what we already know in the care of patients with cerebrovascular diseases and their complications.

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88 Ross Street

Probably no one can practice medicine without being involved in compensation or tort litigation. Here is a gentle reminder that internists and general practitioners cannot escape this and should accept it gracefully and honorably.

The Internist And Workman's Compensation

Jonas Brachfeld, M.D./Willingboro

Internists, unlike orthopedists, rarely are involved in problems of workman's compensation. If one of their patients raises the question, the doctor is likely to regard the matter as a nuisance that will involve him in litigation. The internist often interprets the problem of "causation" in the strictest and narrowest medical sense of the term. He is usually not aware of the broad, legal interpretations which make many illnesses compensable under the law. Internists are even less likely to draw the attention of their patients to this possibility.

However, whether they like it or not, they *are* involved. Whenever they fill in an insurance form (either for sick pay or for hospital benefits) there is a question of whether the illness is covered by workman's compensation. Few internists are aware that they are called upon almost weekly to render, in effect, legal opinions.

These considerations apply particularly to myocardial infarction. New Jersey, for example, no longer requires a true "accident" (or at least an *unusual* form of exertion) for a myocardial infarct to be compensable. In the well known Ford case, it was established that *any* work-related activity which "materially" contributes to the infarction renders the illness, and the subsequent death or disability compensable. This may be either through physical or emotional strain. Compensation applies not only to the period of *acute* illness and recovery, but also to the long term damage.

In some states, such as Pennsylvania, "permanent impairment" applies to the *degree* of inability of the victim to continue at his previous earning capacity in his occupation or in an occupation for which he is qualified. In New Jersey, on the other hand, damage "to the total organism" (as the courts put it, "the loss of physical function which detracts from the former efficiency of the body in the normal pursuit of life") is the sole consideration regardless of whether subsequent employment is at a lower, similar, or higher level of remuneration. An acute myocardial infarction, from which a patient recovered completely and remains completely asymptomatic, which leaves the patient with at least 25 per cent "permanent impairment" is compensable, depending on age. This is not a "shady" or "conniving" transaction but is the patient's legitimate due; and it is a loss against which he has been insured.

Few physicians would deliberately take any action that might prevent a patient from collecting his legitimate due. Unfortunately, neither patient nor physician is often aware of the legal aspects of workman's compensation law.

In any myocardial infarction that even remotely *could* be considered related to any activity at work, the physician should point out to the patient that some type of com-

pensation might be involved and that he should consult a lawyer. In my experience, paients are reluctant to do so and will rely on the opinion of their employer or his personnel officer (an individual who might not be qualified to give unbiased advice in this situation). It is unwise and possibly improper to refer the patient to a lawyer whom the physician knows. It is better to have the patient, no matter how unsophisticated, make his own search for professional legal help. A patient often requires reassurance that this action will not jeopardize his job. He may be assured about this if the claims are factual, devoid of embellishments, or resentful accusations. Lawyers sometimes encourage increasing periods of idleness to make the claim more impressive. I have found it easy to maintain my professional integrity by staying completely out of the problem of compensation once the legal referral has been made and stick to purely medical indications regarding return to work.

Because of potential future litigation, it is important at the outset to document in some detail all activity preceding the onset of myocardial infarction. Sometimes, severe symptoms start only in the evening when the patient has left work. If a history can be obtained of symptoms appearing *immediately after* some activity at work, this history should be clearly recorded. Many other illnesses are equally compensable but few are as common, and yield as "permanent" a disability, as myocardial infarction.

In dealing with lawyers, make it clear that the physician expects to be compensated for his time, for being "on call" and for testifying. A widespread misconception is that testimony fees in workman's compensation cases are limited by the judge. In New Jersey, at least, this is not correct. The court will enter in the judgment a fee for testimony, and the doctor will be sure that he will receive at least that fee. However, the physician is free to make any arrangements with the patient or his attorney as to the fee he will receive for going to court. He thus will be able to render a useful service to his patient and receive just compensation not only for his time but also all inconveniences involved.

I gratefully acknowledge the aid of the Honorable George Neutze, Compensation Judge, New Jersey Department of Labor, in reviewing this manuscript.

Rancocas Valley Hospital

Familial Cancer

Creighton University School of Medicine in Omaha, wants to learn more about patients showing an increased incidence of any histologic variety of cancer in their families. Of particular interest is the "cancer family syndrome," characterized by: (1) increased frequency of adenocarcinoma at any site, particularly of the colon and endometrium, (2) early age at onset of cancer, (3) increased occurrences of multiple primary malignant neoplasms, and (4) autosomal dominant inheritance. To date, they have investigated six families fulfilling all of these criteria (Lynch, H. T., and Krush, A. J.: Heredity and Adenocarcinoma of the Colon, *Gastroenterology* 53:517-527, 1967) and have heard from physicians in Europe who have described two separate and non-related families who also meet the criteria.

If you have patients known to have a familial cancer background, please write to Henry T. Lynch, M.D., Department of Preventive Medicine, Creighton University School of Medicine, 657 North 27th Street, Omaha, Nebraska 68131.

The studies include a genealogic and medical investigation of the entire family in each case. All information obtained will be shared with family physicians in order to facilitate cancer control.

The practitioner should not be panicked at a spontaneous peripelvic urinary extravasation. It is generally benign and conservatively treatable.

Spontaneous Peripelvic Extravasation During Intravenous Urography*

Steven Alexander, M.D. and Bernard D. Pinck, M.D./Passaic

Spontaneous peripelvic extravasation of contrast media during intravenous urography has been recognized more often during recent years. Recent urologic[2] and radiologic[1] literature contains reports which describe this phenomenon. It occurred in patients in whom excretory urography was done during or immediately following an episode of acute ureteral colic.[3] Physicians should be aware of this condition, and prepared swiftly to administer the proper therapy.

Extravasation of dye is produced by a rapid rise in the intra-pelvic pressure caused by an acute ureteral obstruction.[4] This increased intra-pelvic pressure produces a tear in the fornix of a calyx. Urine can then travel into the sinus of the kidney alongside the infundibulum of a calyx. It readily penetrates a porous leaf of the renal capsule to escape around the kidney and pelvis.[5]

Hinman,[6] demonstrated that a potential route exists for the spread of substances between the fornix and peri-pelvic tissues. He administered an azo dye (Pyridium®) to animals and patients with extravasation, and observed that the orange-colored urine traveled through the hilus of the kidney into the peri-renal fat within Gerota's fascia. (See Figure 1) He concluded that this represented an extreme form of pyelo-sinus backflow, and that it was basically a *physiologic* occurrence in the presence of an acute ureteral obstruction.

A calculus is not the only factor in an acute ureteral blockage. Rabinowitz, *et al.*,[7] reported spontaneous extravasation in a patient in whom the ureter was accidentally ligated

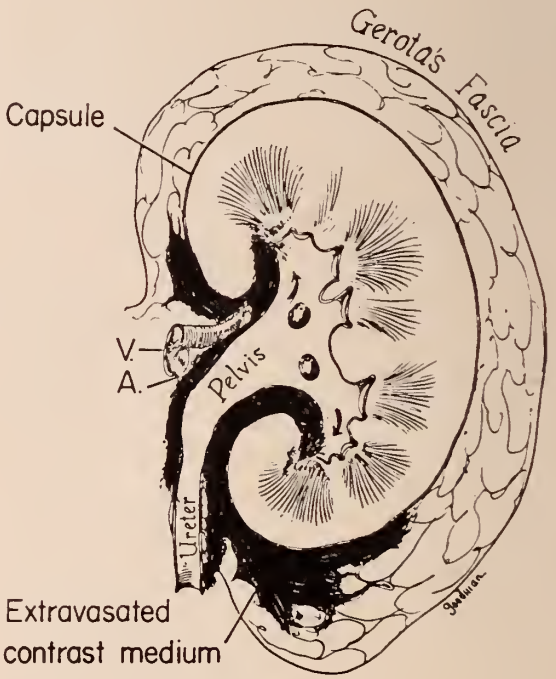


Figure 1

The rupture through the fornices of calyces and the spread of urine into the renal sinus. The urine penetrates a porous leaf of the pelvis and flows into the perirenal fat between the renal capsule and Gerota's fascia. V-vein; A-artery.

* From the Department of Urology, Passaic General Hospital, Passaic.

during a vaginal hysterectomy. The roentgen features of peri-pelvic extravasation of contrast media were clearly observed.

Generally, surgical intervention is not indicated in urinary extravasation associated with ureteral colic. In the past, some patients with this condition were explored. No point of rupture was identified.[8] Once the extra-urinary eruption of dye occurs, it is absorbed mainly by lymphatics, and is rapidly disseminated throughout the body. Subsequent urograms are usually normal.



Figure 2

Intravenous Urogram — 25 minute film showing peri-pelvic extravasation and dilatation of the collecting system.

The extravasation associated with ureteral colic can be differentiated from that due to renal rupture following trauma radiographically.[7] Visualization may be absent with extensive trauma, and the extravasated contrast medium is generally observed within the parenchyma of the kidney, or in a subcapsular position. There may be no filling of the calyces in the damaged area, and there is no evidence of ureteral obstruction. On the other hand, patients with forniceal rupture show dye around the calyx, and the ureter generally is visualized. Re-examination in 24 to 48 hours after onset of an attack will show disappearance of the contrast medium in cases of spontaneous extravasation. However, the roentgenologic picture remains unchanged if there had been an actual rent in the renal pelvis or ureter.

We recently treated a patient with ureteral colic who had an extensive urinary extravasation. The patient was managed conservatively, and, we feel, correctly.



Figure 3

Intravenous Urogram — 3 hour film showing extensive extravasation and splinting of lumbar spine with the concavity to the right.

A 21-year-old female was admitted to the Passaic General Hospital because of right ureteral colic. Her temperature was 101, she had severe right flank tenderness with direct tenderness in the right lower quadrant of the abdomen. White blood cell count was 13,000. The urinary sediment showed pyuria and hematuria. Marked extravasation of contrast media was demonstrated with excretory urography. (See Figure 2). The right ureter visualized on delayed films (see Figure 3).

She was treated with intravenous fluids and antibiotics. Cystoscopy and right ureteral catheterization were not attempted. The pain subsided quickly, and the temperature soon returned to normal.

One week later, intravenous urography showed a normal right kidney and ureter without evidence of extravasation or obstruction. A calculus was never recovered.

Summary

Spontaneous peripelvic urinary extravasation may be demonstrated with excretory urography of patients with ureteral colic. This phenomenon most likely represents an extreme form of pelvic backflow caused by an acute obstruction of the ureter. The extravasate is produced through a rupture of the fornix of a calyx which reaches the peripelvic and periureteral tissues. This type of extravasation is a benign complication of acute ureteral obstruction. It should be distinguished from renal rupture caused by trauma. Instrumentation and surgical intervention are not generally necessary. Morbidity is low. A case is reported to point out the salient features of this condition.

TABLE 1
Comparison of Roentgen Features

Extravasation Due to Ureteral Colic	Extravasation Due to Renal Trauma
(1) Extravasated material around calyx and pelvis	(1) Extravasated material within renal parenchyma or subcapsular
(2) Pelvic dilatation	(2) No pelvic dilatation
(3) Ureter visualizes	(3) No visualization of ureter
(4) Disappearance of dye on delayed X-ray films	(4) No change in appearance on delayed X-ray films

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124 Gregory Avenue

Smoking Truths For Teenagers

As an aid to parents, the American Medical Association has published a new pamphlet, "Your Teen-ager and Smoking." Geared to the parents of teen-agers, the pamphlet provides data on the effect of cigarettes on a smoker's health. It also provides reasons and conclusions why children should not smoke.

A U.S. Public Health Service study is reported which concluded that: (1) The teen-age smoker has a much greater chance of dying from lung cancer, chronic bronchitis, emphysema, or coronary heart failure than the smoker who starts later in life, or the nonsmoker. (2) The earlier a person starts cigarette smoking, the greater the chances are that he will become a heavy smoker. The longer a child puts off smoking, or the sooner he can break the habit, the greater are his chances of avoiding such a fate.

The pamphlet contains practical hints for parents who want to discourage their children from smoking. It urges parents to avoid taking the "it's too late" attitude and present the facts about smoking slowly and patiently. It encourages them to set a good example, respect the child's intelligence and try to destroy the romantic images of smoking.

Review copies are available from the AMA's Department of Health Education. Quantity copies are available from Order Handling (AMA, 535 North Dearborn Street, Chicago) at 15 cents each; 10 cents each for 500 to 999; and 8 cents each for 1000 or more.

This is a talk which Dr. Allman gave in 1957 — twelve years ago! It is reprinted in 1969 to indicate how clear the crystal ball can be. It sounds as if it were written today.

Medicine In A Changing World*

David B. Allman, M.D./Brigantine

The determining factor for survival — as for success — is the ability to adjust to the changing conditions of life, and to overcome them, rather than be overcome by them. The challenge of life *is* change. Change is fraught with peril for those who cannot meet it, but is merely a prologue to new triumph for those who are sufficiently adaptable and resilient to adjust to it.

There can be no growth without change, as there can be no decay. There can be no standing still, either. Change is inseparable from life, and its reverberations seem palely to carry even beyond the frontiers of death. So, we must acknowledge the constancy of change, confront each new change as it comes along, and bend our energies to meeting and besting it. That is our challenge today as members of society, and it is no less our challenge as members of the profession of medicine. And as the poet says:

"Each age is a dream that is dying
Or one that is coming to birth!"

But our times are remarkable — if they are not unique — for the extensiveness of the range of changes which have taken place and are taking place, and the swiftness with which these changes follow one another.

Within a half century — a period of time to which many of us have been eyewitnesses — such a multiplicity of changes have taken place as seem to me to outstrip the sum of all the changes which have come before. There is scarcely an aspect of life which has not been profoundly affected.

Consider the sphere of food alone. . . . The fundamental processes of food raising, cultivation, preservation, and preparation — whether we consider the production of vegetables and fruits or of meats — have undergone radical changes based upon new scientific knowledge applied to plant feeding, crop rotation, irrigation, and mechanization; cattle feeding, transportation, butchering, packing, refrigerating, and canning, cooking, and serving. We enjoy today, as the ordinary accommodations of our tables, viands which in variety and excellence were simply undreamed of, impossible luxuries fifty years ago.

There has been, truly, a happy conspiracy of improvement and progress. Properly basic to this progress and chiefly responsible for it have been scientific inventions and scientific production methods. We have utilized water, air, electricity, coal, fuel oils, and natural and artificial gases to operate the countless new engines and mechanical wonders which add to our ease and comfort. Now we are well on the way to the control and utilization of atomic energy!

Within the memory of living men the gasoline internal combustion engine, the turbine engine, the diesel, the turbo-jet, and the jet have all added their power to the dreams of

* This was the basic speech given by Dr. Allman before some 60 audiences — nationwide — during 1956-1957, in his capacity as President-Elect of the American Medical Association.

men, to make even the most fantastic and ambitious of those dreams come true. The automobile alone has made a contribution to the physical, social, and economic growth of our country sufficient to make this age forever memorable. It has really made us, in a physical sense, the United States of America; for by the network of roads which it has necessitated, it has practically eliminated distances which isolate and insulate and has brought us all — physically at least — nearer as neighbors.

Railroads and airplanes have completed the conquests of distances until today we live in a world of physical intimacy, because the modes of travel have shrunk the severing wastelands and have bridged even the broadest oceans. This is change indeed, making us accessible to foe as to friend, and confronting us with new problems in consequence.

Turn where you may, the story is the same. There have been growth and improvement in every aspect of our material life. Incredible machines decrease man's industrial burdens, but by their productions so increase the national wealth as to afford the worker better standards of living and higher income, though progressively lightening his work load.

In his home the average citizen of moderate means today is served by machines as hitherto no person of wealth was ever served by domestic help. Machines keep his home cool in summer and warm in winter; they warm his water for bathing and cool it for drinking; they cook meals, wash and dry dishes, launder clothes, give him the news of the day, and supply entertainment and instruction by both audible and visible means. By means of electric eyes and closed circuit shortwave radio nursery-units, today machines even mind the baby. About the only things machines do not do for us is beget and bear our children, and we are still too set in our ways — and pleased with them — to want them to do that.

Changes in the sphere of medical and surgical care and treatment have been little short of miraculous. There was a time — and that not long ago — when the members of the medical profession, in America as in the rest of the world, stood in appalling helplessness before the powers of disease and death. The potent processes of infection and debilitation were little understood and ineffectually resisted. Indeed, the basic processes necessary for the maintenance of healthy living were only hazily guessed at. Then, bit by bit, in an atmosphere of anguished hopes and earnest strivings, the balance of power shifted. Step by step the science of medicine expanded; our knowledge of the true causes of disease conditions increased; and methods were discovered and technics evolved — in every department of professional endeavor — which have enabled us to enter into the homes and lives of our fellowmen with the gifts of healing and of health.

The magnificent consequences are familiar to us all. No longer need man creep through life in the oppressive and baleful shadows of disease and death. Now — with buoyant step, in the full sunshine of vigorous, protected health — he can stride along the road of life, free from fear and pain — as in all time, he was never free before.

These are changes which medicine has brought about, good changes for which we can and should all be universally grateful: to man, for his unselfish genius and industry; and to God, for His loving providence.

Relatively few are the diseases that continue to defy us. The shock troops of science are vigorously assaulting the gates of the fortresses of disease which still hold out. If man were not by nature doomed to die, science might even aspire to an eternal triumph. As it is, the average human's life span has become so lengthened as to pose other new problems such as men have never been called upon to deal with before.

In view of all these accomplishments, one might expect that these would be halcyon days of honor and attainment for the men and women of medicine and of widespread satisfaction to all. But to our sorrow we know that such is not the case. Despite the immense

benefits which the doctors of today can confer — benefits ranging widely beyond the most rosy dreams of the doctors of other generations — the doctor's place in society, and in the hearts of his fellowmen, is less honored and less secure than it was when he had fewer benefits to bestow. This is because of other changes which have occurred and are taking place — changes socio-economic in character — changes which we must recognize and deal with for our own good and for the good of society of our day.

We were fortunate in the United States of America that in the days of our beginnings and of our early growth we had high-souled and high-minded articulate leaders who made popular conceptions and principles the most wholesome and the most noble that have ever inspired a nation. Thus, our founding fathers helped us to realize that for the good of all, the rights of the individual in any free society must always be preserved inviolate against invasion. They led us actively to resist as tyrannical, government not based upon the consent of the governed. They made us understand that liberty is the most desirable state for man — enabling him to direct the course of his own life in the pursuit of his personal happiness. And, as a corollary to the concept of individual liberty, they developed an appreciation of the necessity of a spirit of independence and self-reliance. Then they insured this spirit of freedom and independence against deterioration into lawlessness and anarchy, by inculcating the concept of the brotherhood of men under the fatherhood of God.

Love was the leaven which they employed to make certain that the searchings and seekings of vigorously free and independent people would not degenerate into a conflict of selfish desires, but would consolidate into a national strength and a national greatness exemplifying the tranquility of right order. They united our citizens in a dedicated bond of brotherhood and gave to us — and to the world — a new nation, of unprecedented strength and unrivaled greatness.

Love of liberty, responsibility, self-reliance, industry, and resourcefulness . . . *These were* the traits typical of American citizens. Because of them our country grew and prospered. No obstacle was too great, no barrier too broad for the zest of free men, determined by their own strength to achieve security for themselves and for their beloved country. No competition was too keen, no threat too formidable for men and women dedicated to seek and achieve a fuller, freer life. Nothing was able to impede the sturdy march of America and Americans over the road of freedom to the heights of accomplishment and success — nothing, that is, until the corrupt concepts of materialism tainted the minds, contaminated the hearts, and enfeebled the spirits of men.

It was not in America only that the philosophy of materialism made successful inroads. After World War I — which made death, destruction, and privation almost universally familiar — weary men and women were ready for concepts that substituted superficial pleasure for substantial happiness, proximate riches for ultimate wealth, thrills for genuine satisfaction, sex for love, cleverness for wisdom, expediency for principle, and selfishness for sacrifice. Soon success came to be measured not in terms of what had been accomplished but of how little one had to do and how much one managed to get.

The essential drive of Americans remained, but now its character and direction had changed. No longer was it unselfish, moving outward from generous hearts and spirits determined to share their treasure; now it became selfish and narrowing, accepting fleeting material rewards at the cost of eternal spiritual values. In consequence, we learned the deep and bitter truth of Oliver Goldsmith's lines:

"Ill fares the land to hastening ills a prey,
Where wealth accumulates and men decay."

The depression made clear how much had changed. Some Americans — whose ancestors had spurned money for the freedom of living

— wondered if — their money gone — life was worth retaining. Others decided that the task of recovery was too much for them and sought means of bartering their freedom for security. But — thank God — not all so reacted! Some there were who learned that the things of material character which misfortune can sweep away are not essential to human life and happiness. These people found that, in adversity, love and loyalty and justice and truth remain unaffected, and in some instances grow deeper and richer. Such people did not falter; taking heart they re-addressed themselves to the task of making a good living, knowing — what they had not known before — that the making of a good living is definitely secondary in importance to the making of a good life.

The struggle between the philosophy of the material and the philosophy of the spiritual ideal continues. Allegiances are still divided. Our ranks are split; therefore our strength is weak. Today we are a people torn between two influences: the influence of the past — of our traditions and lineage — moving us to exalt freedom, personal responsibility, and individual initiative; and the influence of the present — an influence of opportunism — moving us to get rather than to give, to prefer soft security to militant freedom, to want the laxness of personal irresponsibility, even when it means ceding to other agencies — especially of government—the responsibilities we should retain and discharge ourselves.

We are in danger of becoming a weak and an effete people. We are manifesting alarming inclinations to sell our birthright for a mess of pottage. And the tragedy of it all is that deep down we retain the old undeniable and ineradicable appetites, which our forefathers knew were natural to all men. In consequence, if we ultimately get the mess of pottage, we will inevitably loathe it.

This is the changed and changing world which confronts us Americans today. Thus far the changes have been insidious and gradual, but they have been indicative of a progressive weakening of our national character that could not be more ill-timed. A titan of tyranny is even now contending with us, and with all other free nations, for the dominance of the world. It typifies despotism and all that is contrary to our basic ideals and aspirations. It offers the irresponsibility of bondage for the responsibility of freedom. It exalts the rights of the state over the rights of the individual. It holds out material rewards or punishments as a substitute for spiritual satisfactions. Fear and pain and unrelenting oppressions and cruelties are its regular instruments of administration. It knows nothing of justice or charity. Thus slavery today stands toe to toe with freedom. Now is the time, therefore, when freedom must find full and effective vigor or accept the ignominy of defeat.

In the light of all these circumtances, it seems to me that what we Americans need most today is a new revolution — a good revolution! I use the term in its literal sense. When anything revolves, it pivots through a full circle to return to its starting point. We Americans need to return to our starting point — to our early vigors — of idealism and dedication. There is work to be done of such magnitude that each must do his full and conscientious best if we are to have a decent chance to win and to survive.

In these times every action of any citizen which further enfeebles himself or impairs our national strength is an act of treason. Selfishness, irresponsibility, indifference, opportunism, dishonesty, injustice, and anything else that makes for diminished individual work or lessens our common cooperation is a blow at the heart of our country today. We need a good revolution — a return to the true and lasting good as our fathers saw it and passed it on to us. As citizens and as doctors we must do all in our power to bring that revolution about.

The men and women of medicine have shown no greater immunity to the corruptions of the short-sighted materialism which grips the world than have any others. This is a time

for all to reclaim the best of the past and to rededicate themselves to the best that the future can bring. By word and by action we should strive individually to show the way — through unselfish service and high-souled fulfillment of our duties — back to the true character of the American citizen, which once we owned. The good that continues we must acknowledge and advance. The evil that exists, we must dig out and destroy, or else suffer it to destroy us. Our forefathers are remembered and revered for the effectiveness of their resistance to the tyranny which confronted them in their times. . . . The tyranny of kings.

May we be likewise remembered by those who follow after us for having had sufficient vision to recognize the twofold tyranny of *our* times — the tyranny of Soviet despotism that threatens from without, and the tyranny of selfish materialism that gnaws from within. May we be remembered not only because we had the vision to perceive the evil, but because we had the courage, the high valor, effectively to resist it!

4105 Brigantine Bouvelard

The Psychology of Political Extremism

The author discusses unconscious patterns that motivate an individual powerfully, and often blindly, to hew to an extremist political position. Such extremists, whether right or left, share the following psychodynamic patterns. (1) There is a tendency toward blind faith in a paternalistic leader or leadership. (2) Extreme distortions exist in the perception of the "enemy," accompanied by suspiciousness and distrust that verge on paranoid patterns. (3) The distortions of perception lead toward grandiosity and egocentricity. (4) Conviction is absolute that the responsibility of saving the world rests upon them and consequently they feel quite justified in imposing their views on others by whatever force or violence is necessary. (5) Both extremes manifest an intolerance of ambiguity and a need for certainty. (6) Patterns of repression, denial, rationalization, projection, and reaction formation are strongly evidenced.

In contrast, certain other patterns differentiate the extreme leftist from the extreme rightist. (1) Extremists on the left are oriented against the status quo and in favor of change. The radical rightists are concerned with strengthening of the status quo and are opposed to change. (2) On the left, passive-dependent yearnings for security are linked to the vision of utopia; on the right, to the vision of a past one. (3) The radical leftist views his opposition to the present order as part of an inevitable historical change resting on massive social and economic forces. The extreme rightist tends to attribute all social change to the sinister plotting of malevolent people and never to historical forces. (4) The ideologic content of the extreme leftist is humanitarian and anti-authoritarian; that of the rightist is essentially anti-humanitarian and authoritarian. Structure and content conflict in left wing ideology, but are compatible in right wing ideology. Left wing partisans would be more susceptible than the right wingers to inner conflict and guilt feelings.

The proportion of people in the American population who occupy radical extremes politically is small. This is explained by the democratic structure of the American family with its essentially non-authoritarian parent-child relationships, and the deeply rooted democratic values of our culture

Judd Marmor, M.D.: *Amer. J. Psychother,* 22:561 (October, 1968)

Perinatal Conferences as here described are academically rewarding and intellectually stimulating . . . and sometimes save lives.

The Hospital Perinatal Study Conference*

A Suggested Guide

William J. Farley, M.D./Nutley

The purpose of the Hospital Perinatal Study Conference is to maintain optimal standards of maternal and infant care through the self-evaluation and periodic review of perinatal morbidity and mortality. Its primary function is educational. The production of human beings with maximum potential for normal development is a formidable challenge and a most worthy objective.

Procedure

A. Collection and Tabulation of Data

1. Designation of Co-chairmen. Appoint an interested member of the obstetrical and of the pediatric staff as co-chairmen to supervise the collection of data and the organization of the conferences. Assign a house officer to assist.

2. Fetus and Newborn Record. Maintain a Fetus and Newborn Record with the assistance of the Nursing Supervisor of Maternity and Nursery. Select the following data:

(a) Number of stillbirths (fetal death over 500 Grams)

List whether over or under 2500 Grams

(b) Number of live births (over 500 Grams)

Full-size (over 2500 Grams or 5½ lbs.)

Low-birth-weight (501 through 2500 Grams)

List birth weight of each low-birth-weight infant

(c) Number of neonatal deaths (liveborn infants under 28 days)

Full-size (over 2500 Grams)

Low-birth-weight (501 through 2500 Grams)

List birth weight of each infant

Use the "International Recommendations on Definitions of Live Birth and Fetal Death."** The Perinatal Period II is recommended, i.e., birth weight of over 500 Grams and the period under 28 days. Use low-birth-weight instead of premature, and full-size instead of full-term, in conformity with recent recommendations. Prematurity is reserved for those liveborn infants of less than 37 weeks gestation, and full-term of over 37 weeks.†

The "Maternity Services Record Book" may be used to obtain the number of stillborn and liveborn infants. However, the number, weight, and disposition of low-birth-weight liveborn infants is best kept in a "Premature Book" in the nursery. Infants transferred from another hospital are not included. Each death under 28 days must be reported to the hospital. Subdivide the low-birth-weight infants in the following weight groups:

501 to 1000 Grams = 1 lb. 2 oz. to 2 lbs. 3 oz.

1001 to 1500 Grams = 2 lbs. 4 oz. to 3 lbs. 4 oz.

1501 to 2000 Grams = 3 lbs. 5 oz. to 4 lbs. 6 oz.

2001 to 2500 Grams = 4 lbs. 7 oz. to 5 lbs. 8 oz.

Further subdivisions, below 500 Grams and above 2500 Grams, may be desirable.

3. Perinatal Mortality Case Study Form. It is essential that a *Perinatal Mortality Case Study Form (A)* for each stillbirth and neonatal

* From the Pediatric Service, St. Michael Medical Center, Newark, and the Clara Maass Memorial Hospital, Belleville, New Jersey.

** P.H.S. Publications No. 39, National Office of Vital Statistics, October, 1950.

† World Health Organization Technical Report Series, 1961, No. 217.

_____HOSPITAL Form (A)

Perinatal Mortality Case Study Form

Case No. S_____ Date of Birth_____ ___AM Age at Death___Hrs. Color (or Ethnic Group)_____
L_____ ___PM (Liveborn)_____Days Sex_____ Private__ /Non-Private__
(S = Stillborn, L = Liveborn)

Maternal Data

Age_____ Serology_____ Blood Type_____ Rh_____ Titers?_____ Amniocentesis?_____
Grav._____ ___Para._____ Significant Family History_____ Father's Health_____
Previous Pregnancies:
Full Term Living_____ Dead_____ Stillborn_____ Causes_____
Premature Living_____ Dead_____ Stillborn_____ Causes_____
Abortions or Miscarriages_____ Causes_____
Abnormalities or Complications (Mother & Infants)_____
Present Pregnancy:
Length of Prenatal Care_____ Complications_____
Intercurrent Infections (state Mo.)_____ Other Conditions_____
Drugs Used (Time and Duration of Admin.)_____
Labor and Delivery:
Delivered by Att. Physician?_____ L. M. P._____ Period of Gestation (wks)_____ Presentation_____
Duration of Ruptured Memb._____ Multiple Birth?_____ 1st, 2nd.
Labor Induced?_____ Methods_____ Indication_____
Medications (Am't & Time prior to birth)_____
Hours of Labor_____ 1st Stage_____ 2nd Stage_____ Type Del'y_____ Consultation?_____
If Operative, Indications_____ Difficulties Encountered_____
Anesthesia (Type and Length Admin.)_____
Abnormality of Cord (No. vessels)?_____ Amniotic Fluid?_____ Placenta?_____
*Post-partum Complications:*_____

Date Maternal Form Completed_____

Stillborn Data

Fetal Movements Last Noted?_____ F. H.?_____ Estimated Time of Death_____
Probable Cause of Death_____ Weight_____
Pathological Exam. of Placenta?_____ Findings_____
Autopsy?_____ Findings_____
STAFF COMMENTS:

Date of Conference_____

Infant Data

Case No. L_____ Birth Weight_____ lbs._____ oz. Length_____
Immediate Condition in Delivery Room:
Color_____ Muscle Tone_____ Heart Rate_____ Minutes to 1st Breath_____ 1st Cry_____
Apgar Score at one minute_____ At 5 min._____ On leaving Delivery Room_____
Resuscitation Necessary?_____ Type (describe)_____
_____
_____ By Whom?_____
Stimulants Used (& amount)_____
Course:
Incubator Used?_____ O_2 Needed?_____ Duration_____
Condition, re: Cyanosis_____ Abnormal Respirations _____ Apnea_____ Convulsions_____
Further Resuscitative Measures_____
Findings, re: evidence of Trauma_____ Congenital Malformations_____
Heart Murmur_____ Jaundice_____
Other_____
Feedings (Method, any difficulties)_____
Describe Management in Detail:_____
_____
_____
Pertinent Lab. Data_____ X-Ray_____
Date Infant Form Completed_____

Pathology Report

Placenta_____
Autopsy?_____ Findings_____
_____

Conference Summary

Cause of Death_____ Contributory_____
Staff Opinion (Circle): Ia Ib II III A B C 1 2 3 4 5 6 7 8
Comments:_____
_____

Date of Conference_____

_____HOSPITAL Form (B)

Perinatal Statistical Review Form

PERIOD OF STUDY_____CONFERENCE DATE_____

Total No. of Births	_____	Total No. of Deaths	_____
Total No. of Live Births	_____	Total No. of Stillbirths	_____
Full-size (over 2500 Gm.)	_____	Full-size	_____
Low-birth-weight (501–2500 Gm.)	_____	Low-birth-weight	_____
% of Low-birth-weight to Total Live Births	_____%	Total No. of Neonatal Deaths (501 Gm. and under 28 days)	_____

*Neonatal Death Rate $\frac{\text{(neonatal deaths}}{\text{(livebirths}} \times 1000) =$ _____

Perinatal Death Rate $\frac{\text{(neonatal deaths + stillbirths}}{\text{(livebirths + stillbirths}} \times 1000) =$ _____

Neonatal Deaths by Birth Weight Weight Groups	Births	Deaths	Percentage
Full-size	_____	_____	_____
Low-Birth-Weight	_____	_____	_____
501–1000 Gm.	_____	_____	_____
1001–1500 Gm.	_____	_____	_____
1501–2000 Gm.	_____	_____	_____
2001–2500 Gm.	_____	_____	_____

% of Low-Birth-Weight Infant Deaths to Total Neonatal Deaths_____ _____%

Neonatal Deaths by Age	Number	Percentage
Under 24 hours	_____	_____
24–48 hours	_____	_____
2– 7 days	_____	_____
7–28 days	_____	_____

Neonatal Deaths by Cause	*No. With Autopsy*	*Without Autopsy*
Pulmonary Dysfunction (Atelectasis, Hyaline Membrane etc.)	_____	_____
Cerebral Injury (Trauma or Anoxia)	_____	_____
Congenital Malformation	_____	_____
Infection	_____	_____
Blood Dyscrasia	_____	_____
All Other Known Causes	_____	_____
Unknown Causes		
Prematurity (Immaturity) Unqualified	_____	_____
All other—Unknown Causes	_____	_____
Total	_____	_____
Autopsy Percentage	_____%	

*Rates and percentages are tabulated annually only.

death be completed by the physicians in attendance or by the responsible house officers if a non-private case. The form ought to be completed immediately after death. It may be placed in the physician's record-room chart folder for early completion. This form is an excellent summary for reference in preparation for the conference. Blank forms must be available in the delivery suite and nursery.

4. Statistical Review Form. Complete the *Perinatal Statistical Review Form* (*B*) through the analysis of records and Case Study Forms for a quarterly or annual period for the Study Conference. Subsequently a comparison of each year's experience is possible. The form includes significant data on perinatal mortality relating to birth weight, age at death, and cause of death. Other parameters, such as ethnic groups, period of gestation, and so on, may also be tabulated.

The assignment of a record-room librarian to inform the attending physician of his responsibility to complete the study form, as well as to assist the co-chairmen in the completion of the above statistics, is desirable.

B. Organization of the Study Conference

1. Conferences are scheduled regularly on a given date, preferably every 3 months; more often if desired on active hospital services. The first conference of the new year permits a review of the previous year's statistical record as well as deaths in its last quarter. Allow one month for preparation of forms and pathological reports of the previous quarterly period.

Form (C)

..... HOSPITAL

Date .....

Name of Physician
Address

Dear Doctor:

As you know, the Joint Commission on Accreditation of Hospitals requires pertinent discussion of selected deaths.

We should, therefore, appreciate your discussion of the following case:

(Patient Name)

at the forthcoming Perinatal Study Conference on:

(Date — Time — Place)

If you believe your schedule might prevent you from appearing, please delegate an alternate to appear for you, making certain that your alternate is completely familiar with every aspect of the case.

Yours very truly,
for the CONFERENCE COMMITTEE

2. Attendance must be encouraged. Publish prior notice of the conference and send announcements to the medical staff. *A form letter (C)* is mailed in ample time to physicians attending stillborns and neonatal deaths requesting their presence; particularly of these selected cases judged instructive and worthy of detailed discussion.

The *Department of Pathology* is especially notified of the conference in order to report on those stillborns and infants autopsied and placentae examined. Slides of gross and microscopic material for projection are highly desirable.

The *Department of Radiology* is also given a list of the cases to be presented with roentgenograms for interpretation by the radiologist at the conference.

Representatives from *Anesthesiology, Nursing Services,* and the *Record-Room* are requested to attend. Other Services are invited depending on the cases to be presented.

Attendance of the Intern and Resident House Staff is required.

An obstetrician and a pediatrician may be named as principal discussants to comment on each case. They may be the current attending physicians on Service, or physicians invited from other hospitals, academic practice, or medical schools. An expert and objective opinion is stimulating and informative.

3. *A Case Summary Sheet (D)* is prepared and reproduced for ready reference, containing the pertinent maternal and infant data of each perinatal death of the period studied. The grouping and discussion of neonatal deaths with similar diagnosis, such as small prematures, respiratory-distress syndrome, congenital malformations, and so on, may be expedient with a large number of cases. The hospital charts are also brought to the conference for reference. The case summaries may be placed on a blackboard instead, if preferred. Physicians attending these patients are requested to comment and provide additional information if needed.

Case Summary—Perinatal Study Conference

Form (D)

PERIOD OF STUDY_____ DATE_____

	MATERNAL DATA					*INFANT DATA*			
CASE #	DATE	AGE	GR-P	WEEKS GEST.	HISTORY PRE-NATAL-PARTURITION	AGE	WT.	COURSE FINDINGS & RX.	AUTOPSY FINDINGS
STILLBIRTHS									
S-1									
S-2									
LIVEBIRTHS									
L-1									
L-2									
L-3									

4. Selected case presentations of the most instructive and interesting cases may be distributed and read for more detailed discussion. Information concerning the maternal and infant history, examinations, course, treatment, and laboratory data are included, as in any clinical-pathological conference. The pathological findings are finally reported by the pathologist.

5. An assessment of responsibility, although more optional and dependent on the attitude of the staff, is recommended. An honest endeavor is made following the discussion of each case to evaluate its total management as outlined in the *Assessment of Responsibility Form (E)*. An opinion is expressed by the principal discussants and may be voted on by the conference. The case is then coded with appropriate comments as necessary and entered in the space provided at the bottom of the Case study form (A).

Form (E)

Assessment of Responsibility

I – PREVENTABLE
  a – *Practical* – Present knowledge had not been applied
  b – *Academic* – Possible if unlikely combination of ideal conditions had existed

II – NON-PREVENTABLE

III – UNCLASSIFIABLE – Insufficient data available (may defer for future review)

A – OBSTETRIC
B – PEDIATRIC
C – COMBINED

1. Inadequate prenatal care
2. Family or patient at fault
3. Physician – error in judgment
4. Physician – error in technique
5. Nursing care at fault
6. Inadequate facilities or equipment
7. Intercurrent disease
8. Unavoidable disaster

Each stillborn and neonatal death is coded with an appropriate number, i.e., S-1, L-5, and so on. The patient's name and the physicians' names are *not* placed on the case study form. The completed case study form is *never* attached to the patient's chart or kept in the record room. The coded list and forms may be destroyed after each annual statistical review and report of the conference co-chairmen or committee.

6. Timely lectures by the staff or guest speakers on recent advances in therapy or management may also be scheduled as a part of the conference. This will enhance the educational aspects and interest in the proceedings.

Discussion

The outline above is based on many years of experience in New Jersey hospitals. The format has been satisfactorily employed in the teaching hospital with an approved obstetrical and pediatric residency training program, as well as in the smaller community hospital without participating house officers. Earlier city-wide perinatal mortality studies were instituted in Philadelphia and New York. Our present *Guide* has utilized ideas developed in these previous studies, as well as recommendations of the Committee on Maternal and Child Care of the American Medical Association and the Committee on Fetus and Newborn of the American Academy of Pediatrics. All components of this *Guide* have been tested and have been found practical and workable. *Its successful operation, however, depends on highly motivated members of the medical staff.*

Joint Obstetrical and Pediatric or Medical Staff Conferences are regularly held in many New Jersey hospitals for the purpose of discussing newborn deaths as a requirement for accreditation. All hospitals shall include in their conferences as many suggestions outlined in this Guide as is feasible. Not only may a conference of outstanding academic stature be anticipated, but a greater uniformity of statistics will result. This will provide the opportunity for a year-by-year comparative analysis in each hospital and, in turn, data for regional or statewide studies.

Effective measures to improve the quality of management of mother and newborn infant may also be instituted through acceptable recommendations of its Study Conferences.

A Conference Committee may wish to study other areas of concern. Perinatal morbidity should eventually receive equal attention; the severely damaged infant who lives may still be lost to society and provide an even greater

burden. A better identification and understanding of the special problems of the "high-risk" mother as well as the "small and large for gestational age" baby should be pursued. They must be "tagged" for extraordinary surveillance. Birth weight has been the traditional basis for classification. However, the duration of pregnancy and other indices or combination of these criteria deserve further study.

The heart of any Study Conference is in the constructive sharing of one's clinical experience and scientific acumen with one another. Personal "sensitivity" concerning an understandable shortcoming in management is indicative of a failure of professional maturity. Likewise, unreasonable and unwarranted criticism without constructive and positive suggestion is intellectually dishonest. Neither attiude can be tolerated for it is alien to the fundamental nature of the Conference. In short, culpability is never at issue.

The Perinatal Mortality Study Conference is an excellent medium of communication in an essential area of preventive medicine. It can be a truly rewarding and productive educational experience. This is its goal.

322 Chestnut Street

Alcoholism: disease or disgrace?

Under the title, "Alcoholics and Alcoholism," a New Public Affairs Pamphlet (No. 426) is offered as a concise summary of what is known today about it. Mr. Milt, the author, reviews various treatment possibilities and weighs the chances of recovery. He lists the helping organizations, too. Mr. Milt points out that only a small ratio of heavy drinkers become alcohol addicts. The majority do not. Why does it happen to some and not to others? We surmise that the potential alcoholic has an emotional or physical vulnerability or susceptibility which the others do not.

There is a characteristic pattern of development of an alcoholic. Milt traces four stages, each of which brings "certain changes in drinking habits. personality, emotional response, intellect, interpersonal relationships, and social behavior." This section on alcoholics and alcoholism will be particularly illuminating for anyone concerned about his own or a relative's drinking patterns. Recovery, he thinks, is possible for a large proportion of alcoholics, if we are talking of "long-term or permanent maintenance of abstention. Aside from the effectiveness of the treatment methods themselves, another important factor must be taken into consideration, and that is the stage of the addiction as well as the nature of the attending psychiatric disorder." Best prospects for treatment are those who have been socially involved, who have had good achievement in work, business, or raising a family, and who have the capacity for warm interpersonal relationships.

The major treatment methods in use today — and which Milt describes— are individual and group · psychotherapy; alcohol-antagonizing therapy; conditioned-reflex therapy; Alcoholics Anonymous.

Milt pays special tribute to the pioneering and continuing efforts of the Rutgers Center of Alcohol Studies and the original Center at Yale, the National Council on Alcoholism, and the North American Association of Alcoholism Programs. For the future, he looks for increased research and treatment and prevention programs stimulated by the National Center for Prevention and Control of Alcoholism of the National Institute of Mental Health and by community initiative.

The pamphlet may be purchased for 25 cents from the Public Affairs Committee at 381 Park Avenue South, New York City 10016. Ask for Pamphlet No. 426.

In this unique paper, a seldom reported interrelationship between diabetes and vitiligo is described and illustrated.

Diabetes With Vitiligo

Manual M. Villaverde, M.D./Woodbridge

A thorough search of the medical literature disclosed only an incidental observation of a patient with diabetes plus vitiligo. This was described by Sézary,[17] who attributed the discoloration to pancreatic influence. On the other hand, vitiligo has also been reported in association with systemic diseases (hypo- and achlorhydria, pernicious anemia, among others) and with a large number of endocrinopathies, such as Simon's disease,[2] hyperthyroidism,[4,8,14,16] goiter,[12] hyperparathyroidism,[15] Addison's disease,[1,8,9] female eunuchoidism.[6] In spite of the large number of dermatologic conditions reported in association with diabetes, vitiligo has not been considered as one of them until our publications.

For a few years, patients with vitiligo were referred to us for endocrinologic evaluation. No significant data were obtained, perhaps except a few details pointing out some sort of pituitary insufficiency, such as low basal metabolism, increased sugar tolerance, some abnormalities of the sella turcica, among others. We did not notice a higher incidence of diabetes among patients with vitiligo, or of vitiligo among diabetics. But according to Dawber,[3] a significant, increased incidence of vitiligo was found among diabetic patients (5 per cent) when compared with non-diabetic controls (less than one per cent), with a predominance among females.

The significantly increased incidence also emphasizes that this is something more than a simple coincidence, that there is possibly a combination of symptoms in a syndrome produced by a similar original cause. This was pointed out by us[18] after following the course of a climacteric woman presenting diabetes, vitiligo, obesity, hypertension, and epidermophytosis interdigitalis, in whom diabetes and vitiligo followed a parallel course (worsening, improvement, worsening).

Since the study of our first cases, we tried to gather all similar patients known to us. We were able to acquire direct knowledge of six such cases, to which three seen by the late Prof. Marañon (Madrid) and one by the late Dr. Montoro (Havana) were added, thus making a total of ten cases. The data furnished by these patients gave us a firm base upon which to discuss the problem as the syndromic combination of diabetes and vitiligo.

Case One

This was a tall, asthenic man born in Spain who at the age of 62 developed diabetic symptoms following the death of his daughter. At about the same time he also developed vitiligo. In the family there were other diabetic patients, patients with goiter, and quite a few with congenital anomalies. In spite of the poor care of the disease, he developed no important diabetic crises. He died at the age of 74 of an infection caused by prostatic procedures.

Case Two

This 42 year old pyknic woman was referred by a dermatologic service because of obesity with a plus 32 basal metabolism. Her vitiligo first appeared when she was 39, and the diabetic condition was detected by blood tests during our consultation. The sella turcica was large. Following treatment (caloric restriction, 10 to 20 units of insulin, iodinated compounds and vitamins) all symptoms improved. The vitiligo almost disappeared and we came to doubt the validity of our diagnosis of diabetes. Two years later she came again to our office presenting once more all the symptoms of diabetes and vitiligo, plus hypertension and obesity. She never used more than twenty units of insulin, nor suffered important metabolic disturbances.

Case Three

A 75 year old pyknic woman, with hypertension and large liver, developed diabetes and vitiligo a few years prior to consultation. She used 70 units of insulin, but never suffered from diabetic crises.

Case Four

A 37 year old asthenic woman had moderate hypertension, goiter with a minus 31 basal metabolism, and vitiligo that had been present since she was 10 years old. During two pregnancies, there was some improvement of her vitiligo. Both deliveries were by forceps. Diabetes was discovered during our first consultation. The sella turcica was frankly enlarged and the skull showed signs of endocranial hyperostosis, calcified pineal body, and large sinuses. Phosphoremia and the sedimentation rate were increased. She had many relatives with diabetes.

Case Five

This patient was a 48 year old asthenic man with an anomaly of his left arm. His vitiligo appeared after the onset of diabetes. His mother was also a diabetic.

Case Six

A 52 year old asthenic man had diabetes since the age of 30 and vitiligo since 45 (almost simultaneously with the death of his mother and sister). Large liver and large sella turcica were present. He took poor care of himself, but never had diabetic crises. Occasionally, albuminuria, hypertensive crises, and xanthoma on the elbows manifested themselves. There was an excellent response to oral hypoglycemic agents.

Case Seven

This was seen by the late Dr. O. Montoro. At age 32, a woman consulted him for the first time because of diabetes and goiter. At 45 she developed psoriasis, and at 49, vitiligo. Finally, she had bilateral cataracts, cholecystitis, and moderate hepatomegaly. She never used over 16 units of insulin, and never experienced diabetic crises.

Other Cases

Additional cases were seen by the late Prof. G. Marañón, who, in a letter to me, described them as "cases with mild diabetes of erratic course and erratic reactivity to insulin, also showing vitiligo."

The clinical picture of the patients may start with either diabetes or with vitiligo, usually at about the same time. Any of the signs of diabetes may appear first, and vitiligo appears in the habitual areas (dorsal surface of the hands, elbows, forehead). Half of the patients showed a large, smooth, painless liver of normal consistency and without signs of hepatic damage. Blood pressure may be normal or high. Most patients had low basal metabolic rates. Some also had a goiter. The sella turcica appeared large and not entirely normal in shape in all x-rayed patients. Diameters over 15 millimeters are common, and we can see also endocranial hyperostosis, large clinoids, and flat sellae.

The clinical course is favorable in that there are very few (if any) diabetic crises, even though many of the patients paid little attention to themselves. In one instance, a parallel course of both diabetes and vitiligo was found. When vitiligo improves, there is improvement in the diabetes, and *vice versa*.

All cases recorded up to now were in white people. There is a slight predominance of women over men and of the asthenic type over the pyknic. Not all the patients belonged to families with a history of diabetes, but in many we were able to record a large number of congenital anomalies, both in the patients and their families (brachydactyly, small stature, endocranial hyperostosis, bone anomalies, scoliosis). The onset was often related to a crisis in life, such as puberty, the climacterium, or violent emotions.

Diabetes and vitiligo, as seen in our patients, strongly suggests an interrelationship. This is so because of the parallel course followed by one of the patients, because of the absence of important diabetic crises in spite of the poor care given to their conditions, and because of a few signs and symptoms present in most cases pointing out a relationship with the hypophyso-hypothalamic block function. The concept of a hypopituitaric origin of vitiligo is willingly accepted after Zondek and Krohn[26] found a melanin-stimulating hormone in the hypophysis, and after its favorable effect upon vitiligo, as shown by clinical essays.[13] The active role of the pituitary upon carbohydrate metabolism and upon the development and course of diabetes is well known.[5] In the first instance, the Houssay phenomenon reveals that the resection of the pituitary is followed by the improvement of a previous diabetic state. Also, there is a known diabetogenic influence of the gland upon carbohydrate metabolism through the action of the somatotropic or growth hormone.[7] In addition to this, there is also a more direct or indirect glucide metabolic effect of the pituitary through the action of

some of its hormones, namely, prolactin, ACTH, and the thyroid stimulating hormone (TSH). Some sort of insulinogenic influence was found in the earlier gonadotropic extracts or prolans.[24] Nor should we forget the diabetogenic effect of some hyperfunctional diseases of the hypophysis, such as acromegaly and Cushing's disease. Conversely, decreased pituitary activity will reduce diabetic activity.

Considerable data suggest pituitary participation in the pathogenesis of the combination diabetes-vitiligo. In the first place, the presence of vitiligo itself. Second, some phenomena that could be attributed to a hypofunctional hypophysis. Among these, there are: the use of forceps because of inertia of the uterus; congenital anomalies (sometimes considered to occur together with some impairment of the hypophyso-hypothalamic block);[10,25] the frequent onset of the complex diabetes-vitiligo during critical periods of life (menarche, climacterium), when the pituitary is playing an active role; the prevalence of a low basal metabolic rate; and the finding of a not entirely normal sella turcica.

We can speculate that the combination of diabetes and vitiligo may result from: (1) a pituitary-hypothalamic lesion causing both diabetes and vitiligo; (2) a pure lesion of the pituitary that through a lessened activity of the gland provokes vitiligo (decreased melanine-stimulating hormone) and diabetes (milder source in an ordinary diabetes, due to global insufficiency or to decreased secretion of the somatotropic hormone, or due to the decreased secretion of a pancreatotropic factor).[11]

In case 2, the alternate improvement or worsening of either condition, diabetes or vitiligo, was accompanied by parallel improvement or worsening of the other — not by the worsening of diabetes following the improvement of the skin discoloration (as it had to occur if the insufficiency of the pituitary was the cause of vitiligo and of the mildness of a previous independent diabetic condition). For this reason, we favor the hypothesis of a pituitary insufficiency (either primary or due to a hypophyso-hypothalamic lesion) leading to both vitiligo (less melanine-stimulating hormone) and diabetes (a lessened stimulation to pancreatic or other diabetogenic factors).

Summary And Conclusions

1. Patients are presented who had diabetes plus vitiligo. Diabetes was mild in all cases, and frequent findings were an abnormal sella turcica, congenital anomalies, hypometabolism, and a more or less moderate hepatomegaly. These data suggest a relationship of the syndrome to the hypophyso-hypothalamic block.

A bibliographic listing of 26 citations appears in the author's reprints.

Woodbridge State School Hospital

Booklet On Hypertension

Written for the intelligent layman, a 48-page booklet is now available through the National Institute of Health. Entitled *Hypertension,* it describes how blood pressure is measured and how it is controlled. There is a frank discussion of what we know and don't know about the causes of hypertension, and a candid review of the therapies available. The brochure concludes with a good glossary and a chapter on the research outlook. A physician may obtain a single copy free from the Heart Information Center, National Institute of Health, Bethesda, Maryland 20014. Or, you may obtain copies in quantity (50 cents each) from the Superintendent of Documents, Washington, D.C. 20402.

New possibilities are here shown for three-dimensional brain surgery.

Stereotaxic (Three Dimensional) Neurosurgery*

George A. Zazanis, M.D. and Henry R. Liss, M.D./Morristown

In 1908, Horseley and Clark[1] devised an experimental tool for making precision electrical lesions in the cat brain for neurophysiologic investigations. The ubiquitous cat was chosen because there is so little variation in the shape of its skull and bony landmarks can be consistently used as reference points.

Spiegel and Wycis[2] in 1947 designed a stereotaxic apparatus for human use. They used the internal ventricular landmarks of the brain as reference points because the bony landmarks of the human skull vary too greatly. Initially patients were treated for psychiatric disorders since it was felt that more discrete lesions could be made in the dorsomedial nucleus of the thalamus where the frontal lobe projection fibers come together and thus avoid the complications of frontal lobotomies.

The availability of ataraxic drugs brought a decline in surgical management of these problems. Today, however, there appears to be a renewed interest in the surgical treatment of psychiatric disorders, behavior problems, and epilepsy. Here the stereotaxic or "three dimensional" approach (to the deep and delicate brain structures) seems especially appropriate. Lesions are made in the thalamic dorsomedian nucleus, the cingulum and the amygdala.[10,11]

Cooper[7] showed that anterior choroidal artery ligation in the patient with Parkinson's Disease was followed by relief of the tremor. Thus, basal ganglia diseases came under more intensive investigation and have continued to be the main area treated with stereotaxic surgery. These diseases include extrapyramidal or movement disorders such as Parkinson's Disease, hepatolenticular degeneration of Wilson, Huntington's Chorea, athetosis, choreoathetosis, dystonia musculorum deformans and hemiballismus.

The globus pallidus was the first basal ganglion structure ablated. Due to a high incidence of post-operative hemiparesis, the thalamus and its ventro-lateral nucleus became the target area. This post-operative paresis and (in bilateral lesions) mental aberrations encouraged Spiegel and Wycis[2,3,4] to turn their attention to the destruction of Forel's Field. They called the procedure a campotomy so named after the latin "Campus Foreli." Lesions are made in the thalamic part of field H rather than the mesencephalic part.

Forel's Field H, H and H_2 are the crossroads of the basal ganglia system. Pallidofugal fibers pass to the nucleus of Forel's Field which then sends fibers to the red nucleus. Some fibers bypass and end in the red nucleus directly. The rubrothalamic and cerebellothalamic fibers also go to the ventrolateral nucleus of the thalamus. Corticofugal fibers bearing impulses to this prerubral field also pass through as do some hypothalmofugal fibers and ascending fibers from the reticular formation.

Intractable pain has also been treated by the stereotaxic method. In 1964 Reichert[8] noted

* From the Morristown Memorial Hospital, Morristown, New Jersey.

his results in the treatment of thalamic syndrome, pleural and visceral pain, phantom limb, anesthesia dolorosa and gasserian ganglion pain with some mild success.

The target area includes the spinothalamic tract in the mesencephalon and the sensory nucleus of the thalamus in the basal part of the ventroposteriolateral and ventro posteromedial nuclei. The dorsomedial and anteromedial nuclei of the thalamus have also been ablated and in this manner sensation can at least be partly preserved without disagreeable side effects such as dysesthesiae.[5,9]

Behavior disorders are also considered. Interruption of the Papez circuit including forebrain structures, cingulum, fornix and the amygdala is theoretically accomplished.

The amygdala lie in the temporal lobe just anterior to the temporal horns of the ventricles and inferior to the optic tract.

Ablation of these areas requires an apparatus which is simple, accurate, safe, and light. Rigid and repeated accurate fixation to the skull must be obtained. Different methods have been used including those devised by Walker, VanBuren, Ward, Guiot, Bertrand and Spiegel and Wycis.



Figure 1 — Stereotaxic Atlas.

Method

For movement disorders we do a campotomy. To make a lesion in Forel's Field, one refers first to a stereotaxic atlas by Spiegel or Bailey. Brains have been photographed and the target area can be plotted (See Figure 1). It can then be predetermined that the Field H lies 6-7 millimeter lateral to the sagittal plane in the midline and about 10-12 millimeter anterior to the posterior commissure.

The skull is prepared and screws are placed for fixation of the apparatus. The stereoencephalotome is fixed to the skull with reference to Reid's baseline, the external landmark. (See Figure 2). A ventriculogram is performed with the apparatus in position. The anterior-posterior commissural line of the third ventricle is outlined with Pantopaque. Then corrections for x-ray enlargements are calculated and the lesion site is plotted on the x-ray film. (See the AP and lateral x-ray shown in Figure 3 and 4.) The fine piano wire elec-



Figure 2 — The Stereoencephalotome.

trode is directed through a burr hole about 1.5 centimers lateral to the external midline in the sagittal plane. Careful surgery is required near the sagittal sinus to avoid air

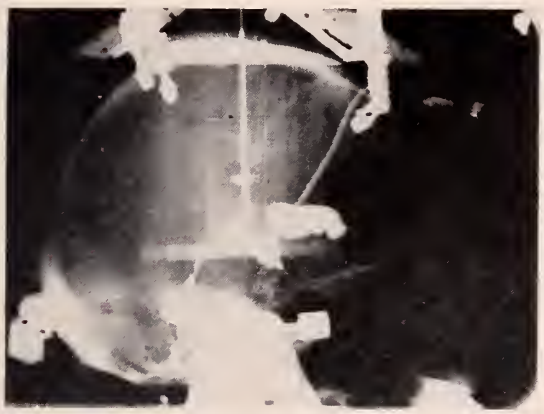


Figure 3 — Ventriculogram. Lateral view with stereoencephalotome in place.

emboli and excessive bleeding. A physiologic stimulus is produced by applying a 15 volt square wave stimulus with a frequency of about 30 cycles per second and a pulse duration of 2 milliseconds. During stimulation the patient is examined for increased tremor, eye changes, and other abnormal motor movements. If the electrode is placed incorrectly



Figure 4 — Ventriculogram. AP view with stereoencephalotome in place.

in the internal capsule, clonic movements due to the stimulus may be seen. Involuntary jerking movements of the eye indicate that the electrode is posterior to the target and the current may be applied to the third nerve nucleus or its fibers as they traverse the red nucleus. Dysesthesiae indicate that the electrode is placed too far postero-laterally. Aggravation or diminution of the Parkinsonian tremor during stimulation is considered a physiological confirmation for a correct electrode position.

A lesion is then made utilizing a fractionated, direct, anodal, unipolar current of 10 milliamperes for 60 seconds. Usually eight lesions are made in the postero-lateral and antero-medial planes beginning 2 millimeters above the target which lies on the commissural line near its midpoint. The needle is advanced in

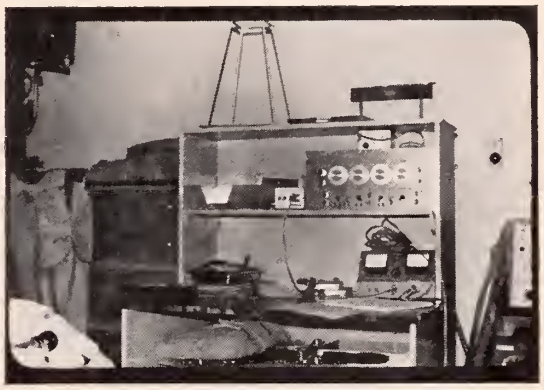


Figure 5 — The Electronic Apparatus.

2 millimeter increments usually to end 6 millimeters below the commissural line. Neurological examinations are performed frequently between and during lesions and stimulations. (See Figure 5 picturing the electronic apparatus).

We have made lesions in other areas of the brain such as in the amygdala. They are similarly made using different reference points and internal ventricular landmarks nearer to the target for greater accuracy. The amygdala target is just anterior to the tip of the temporal horn which is outlined with Pantopaque.®

The neurolesion unit is custom made by Charles Zanes of the Department of Medical Physics, Temple University, Philadelphia, Penna. (See Figure 5 picturing the Grass electronic apparatus). S-4 stimulators and S-10478 models are used. The stereoencephalotome is made by J. J. Schmidt Company of Edgemont, Penna.

CASE HISTORIES

(The patients are numbered in chronologic order of performance of their procedure and grouped as to the quality of the results)

Results		Age/Sex	Diagnosis	Procedures	Comment
	(5)	60 F	Parkinson	Campotomy	
Group I	(10)	65 F	Parkinson	Campotomy	
Excellent	(12)	20 M	Behavior	Bilateral Amygdalotomy	
	(1)	53 F	Parkinson	Campotomy	
Group II	(4)	50 M	Parkinson	Campotomy	
Good	(7)	50 M	Parkinson	Bilateral Campotomy	Transient Hemiparesis
	(13)	68 M	Parkinson	Campotomy	
	(11)	40 M	Multiple Sclerosis Tremor	Campotomy	
	(3)	55 M	Parkinson	Campotomy	Previous Thalamotomy
Group III	(6)	14 F	Athetosis	Bilateral Campotomy	Mental Changes
Fair	(8)	64 F	Parkinson	Campotomy	Bradykinesia
Group IV	(2)	62 M	Parkinson	Campotomy	Air Embolus Now Improved
Poor	(9)	57 F	Parkinson	Bilateral Campotomy	Rigidity

Case Histories

In considering cases 5 and 10 where "excellent" results were obtained, the patients had predominately unilateral tremor with little rigidity and bradykinesia. Patient 5 had a mild transient post-operative hemiparesis and has been absolutely free of tremor. However, she has not returned to previous gainful employment for personal reasons. This could be due to a slight intellectual deficit following the surgery which was on the dominant side although she is not aphasic. Our patient number 12, with the behavior disorder is a twenty year old man with mental retardation who had outbursts of violent activity requiring such high sedative doses of medication prior to surgery that he was rendered comatose. Following surgery he has become very quiet, and docile. Patients 1, 4, 7 and 13 are listed as "good" results in that their functional status improved but tremor and rigidity were not completely relieved.

For patient Number 1, we are indebted to Dr. H. Wycis who directed this, our first case. The patient's ability to do housework improved but in the last few months her tremor is again worsening and she may need contralateral surgery. Patient 4 was institutionalized and in a wheelchair prior to surgery. His general comfort improved and he was able to feed and help himself following surgery due to the relief of his rigidity, his main sign and symptom. Recently he died following a coronary occlusion and it was our bitter disappointment not to obtain a post mortem examination.

Patient 13 was treated for bilateral tremor and rigidity more preponderant on the left side. A retired speech professor, he still complains of his weak voice and easy fatigue. However, tremor and rigidity are now minimal. Patient 7 had an excellent final result in that the tremor was totally relieved. Because of a rather prolonged transient hemiparesis, we can classify his status only as "good." The operation was on his dominant side. He is functionally and emotionally much improved in his employment although he has a residual, very mild weakness. Because of the total relief of tremor (and in spite of the paresis) he shows euphoric gratitude. Pre-operatively his tremor was violent and he had a mild facial weakness which may have some bearing on the development of this complication. The spasticity in this man's extremities was benefited by phenol injections perineurally by Dr. Robert Steinman of the Morristown Memorial Hospital, Department of Physical Medicine. We work closely with our physiatrists, Doctors Lasoff and Steinman, whose efforts contributed measurably to all our patients' benefit. Currently their speech therapists evaluate our patients pre- and post-operatively, and hopefully we will be able to report these results.

Our multiple sclerosis patient (patient 11) is still under treatment. Since the surgery on his

initial side was completed, the contralateral tremor was measurably reduced. This markedly impaired man can now feed himself. His head tremor has not been helped, however, and it continues to be his most urgent complaint. His wife is dissatisfied because he has not been totally rehabilitated.

Special attention is directed to No. 6, who has double athetosis due to Rh incompatibility. Bilateral campotomies have been done on this patient. Her movements have been reduced in amplitude. According to reports from her teachers and psychologists, an increased post-operative learning deficit is present. Extensive physical therapy will be necessary for her fully to realize the potential now increased in her. This again illustrates the necessary team approach, and commitment on the part of both the medical and surgical specialists.

Regarding our "fair" results, patient 8 had had a measurable relief of marked tremor and rigidity following surgery. Retropulsion was a post-operative difficulty for this patient. Her hospitalization, however, precipitated her transfer to a nursing home because she was too difficult to manage at home. Her husband, however, tells us she gets out each weekend to dinner and he is satisfied with her present condition. Number 3 had a thalamotomy done by Doctor I. Cooper of New York in 1962. At that time an initial post-operative hemiparesis was followed by recovery and reduction of tremor but not rigidity. The contralateral campotomy by us, therefore, was approached with caution since too large a lesion could encroach on the thalamus and result in emotional and behavioral changes. Also, the internal capsule could have been involved and another more serious paresis precipitated. Rigidity was measurably helped but the tremor only slightly changed following our campotomy. Repeated surgery is probably not indicated.

Number 2 entered with a pre-operative unilateral tremor. Air embolus during the surgery left him with a hemiparesis contralateral to the tremor. A long, stormy post-operative course followed, and his life was saved only by the devoted care of the medical staff. At present, tremor has improved following the surgery. The hemiparesis is present but improving. He cannot work but is independent, although essentially worse than he was preoperatively.

Number 9 was first seen with bilateral tremor. A right sided campotomy was done and a dramatic relief of left sided tremor and rigidity followed. In two months the contralateral tremor worsened and would "spill" to the left side. In six months a left-sided campotomy was performed. Progressively she developed severe left-sided spasticity and right-sided rigidity. A peculiar acute angular flexion was noted at both wrists. More recently this tremor has returned bilaterally, although initially a marked reduction was noted. She now has to be fed and has reflex pseudobulbar swallowing. She is confined to a wheelchair and is in a nursing home although she was completely independent prior to her surgical procedures.

Conclusion

Our results are consistent with other well documented reports.[4] We have no operative or post-operative deaths. Two serious complications are present in a series of 13 patients and 17 operations. We are impressed by the strikingly excellent result obtained in the patient with the very severe behavior disorder. We concur with others working in this field that Parkinson's Disease is a complicated entity and that surgery helps only tremor and rigidity. Bradykinesia is not relieved with surgery and in one of our cases may have been worsened. With the extensive pre- and post-operative evaluation of speech, motor function, and psychological status, a rapport develops between the surgeon and his patient. This may account for some of the gratitude expressed by these patients who know drugs are failing them, incapacity is increasing, and that finally someone is "doing something." Those patients with Parkinson's Disease were especially grateful for the release of the rigidity in addition to the diminution of the more obvious tremor. Good results can be expected in over 75 per cent of cases.

There are two serious complications. We have learned to avoid the sitting position and keep the wound covered with saline so as to prevent another air embolus. Bilateral stereotaxic procedures for Parkinson's Disease are to be approached with caution since interruption of the corticobulbar tracts can result in a totally incapacitating pseudobulbar syndrome.

In reviewing the chronologic order of the procedures performed, it seems that to some degree at least, improvement is noted with the increased experience in technic, better selection of patients and more understanding of the pathophysiology.

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290 Madison Avenue

You And The Occupational Health Registry

Have you treated a patient recently who had a health problem related to his occupation?

The American Medical Association's Registry on Occupational Exposures is collecting data and needs your assistance. This Registry has been gathering information for two years. It has some single reports of unusual reactions, but not enough confirmatory information to substantiate a causal relation.

Several of the reports suggest that previously unrecognized syndromes may result from exposures to materials whose toxicity is already established. Other reactions reported are well known to the expert but not recognized by the occupational physician who is inexperienced in these matters.

The Registry is under supervision of the Committee on Occupationl Toxicology. Any information on occupational exposures to potentially hazardous substances should be sent to the Registry at the AMA headquarters Department of Occupational Health, 535 North Dearborn Street, Chicago, Illinois 60610.

The Committee has been disappointed in the low volume of reports submitted to the Registry. It urges *all* physicians – not just occupational health physicians – to keep the Registry posted on ailments that may be related to adverse occupational conditions. Do not submit information on injuries and accidents. Some companies are understandably reluctant to provide information, even though the Registry procedures are designed to guarantee complete confidentiality.

The Committee's purpose in initiating the Registry was to create a professional repository for information storage, retrieval, and dissemination of new information to professionals charged with protection of workers.

A simple and effective technic for rectal tamponade in infants is here outlined.

Vaginal Tampons In Anorectal Surgery In Infants*

James F. Densler,M.D.;
Luis Parodi-Hueck, M.D.;
Richard C. Reed, M.D./Newark

Anorectal surgical procedures are infrequent in infancy. One of the most common anorectal operations in infancy, in our experience, has been a rectal biopsy for megacolon. To facilitate better exposure and to keep the operative field free of feces and fluid a new type expandable vaginal tampon**[3] has been used as rectal packing. (See Figure 1) This tampon is used instead of the saline moist gauze sponge recommended by several authors.

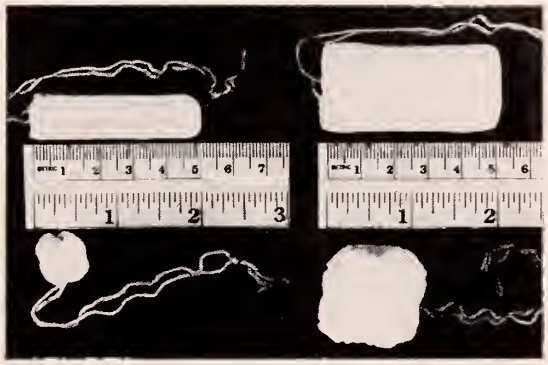


Figure 1
Longitudinal and vertical views of the vaginal tampon** before (left) and after (right) moistening.

The method used to obtain a biopsy of the rectal musculature follows the technic proposed by Swenson[2] with a few modifications described by Rowe.[1] After the infant is positioned, prepared, and draped, the anus is gently dilated with a finger. A dry tampon**[3] is inserted high in the rectum. The fluid in the rectum plus aqueous Zephiran® put in the rectum cause the tampon to expand in place. (See Figure II) At the completion of the rectal biopsy the tampon is gently removed by the attached strings and another dry tampon is inserted over the site of biopsy and soaked with aqueous Zephiran.® This tampon is usually removed in 4 to 8 hours postoperatively.

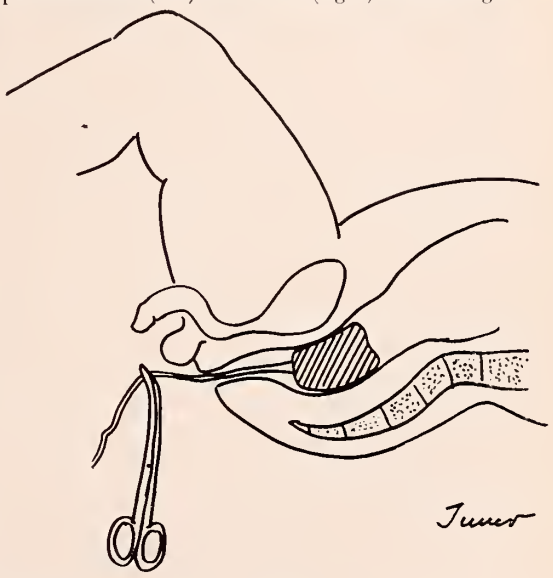


Figure 2
Diagram showing the tampon in place high in the rectum.

Tampons have been used for packing in several rectal biopsies on infants and when doing anoplasties, fistulectomies, and other

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** CAREFREE Vaginal Tampon by Personal Products Company.

anorectal procedures in older children. The tampons are easy to insert and remove and efficient in preventing fecal soiling during the operative procedure. They have also been found to be effective in the tamponade of oozing in the anorectum postoperatively.

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15 Roseville Avenue

Emotional Adaptation to Pacemaker and Open Heart Surgery

In 1969 approximately 10,000 patients will require a temporary or permanent pacemaker, and 30,000 to 50,000 will undergo heart surgery. To the patient, such therapies are usually catastrophic experiences which necessitate a major rearrangement of his concept of himself and his life situation. In the writers' opinion, every patient undergoing heart surgery should be seen by a psychiatrist. This paper presents their observations on 60 open heart and pacemaker patients compared with a control group of general surgical patients matched in age, sex, and race.

The reaction to the surgery was measured and observed on a "flow chart." On this chart the essential responses of the patient from hour to hour, or day to day, or week to week were recorded; this record was useful in monitoring the patient's adaptive response to the stress and in measuring clearly the direction of his total psychologic response. A healthy usual response to surgery was a moderate amount of anxiety, some mild depression, an awareness and acceptance of the illness and the risks, a state of hyperpreparedness, and a realistic determination to survive. Patients were found to pass through one or more of 6 dynamic phases after the cardiac episode: (1) shock; (2) impaired ego defenses with or without psychosis; (3) presymbiotic; (4) symbiotic; (5) resolution of symbiotic union; (6) return to premorbid personality. Participation by a psychiatrist through all these stages facilitated their resolution.

All patients suffered from some degree of sleep deprivation and sensory isolation during the postoperative period in the cardiovascular unit. Dreaming was uncommon. The lack of REM sleep may account in part for the agitated, hallucinatory delusional period seen in some patients. Interrupted sleep was the result of frequent and necessary medical checks and manipulations and of the peculiar ego status of the patient. Because of the overwhelming presence of the apparatus, and inability to communicate adequately with the people around him, each patient became attached to the apparatus, and they became part of him and he part of them. Some patients suffered postoperative memory impairment. Many of them, however, could with careful assistance and persuasion reconstruct events and memories at a later time. The amnesia served as a defense to cope with the stress of surgery. Other patients used a more primitive defense; they actually believed themselves to be dead. Preoperative management includes psychiatric evaluation and the establishment of a meaningful doctor-patient relationship. Postoperative management is based on the continuing relationship with the patient, appropriate explanation and reassurance, meaningful human contacts, and the use of appropriate drugs according to the needs of the patient.

Dlin, Barney M., M.D. and Huddell, Benjamin, M.D.; *Arch. Gen. Psychiat.,* 19:599 (November, 1968)

Cardiac pacemakers are good, not only for internal cardiac disorders but, sometimes, for lower extremity ischemia, too.

Endocardial Pacemakers In Lower Extremity Ischemia*

William H. Hardesty, M.D./Trenton

Cardiac pacemakers are an accepted method of controlling ventricular rate in patients with Stokes-Adams attacks. Cerebral blood flow is increased by increasing cardiac output in these patients with atrioventricular block.[1] Two patients recently benefited in a different way by insertion of endocardial pacemakers.

Case One

An eighty-five year old female had been in good health until the day before admission to the Mercer Hospital when she had the onset of intermittent syncopal episodes. She had been taking digoxin, 0.25 milligrams daily for the past five years. Her pulse rate on admission ranged from 35 to 140. Blood pressure was 190/90. A large abdominal aortic aneurysm was noted. Her extremities were warm and of good color but pulses could not be felt in either foot. An electrocardiogram on the day of admission showed ventricular tachycardia. Hemoglobin was fourteen grams. The white blood count was 13,300 with a normal differential count. A urinalysis showed 100 milligrams of albumin with thirty to forty white blood cells. B.U.N. was 22 and F.B.S. was 122 milligrams. Serum potassium was 3.5 meq., sodium 140 meq., and calcium 5.2 meq.

Digitalis was stopped and potassium chloride and Pronestyl® given. Following this, she converted to a rate of seventy-six with a regular sinus rhythm. Twelve hours later, a convulsive episode was associated with an attack of ventricular tachycardia and later more frequent attacks of ventricular tachycardia occurred. Her right foot became pale, bluish, painful, and eventually numb. Attempts at medical control were unsuccessful. An endocardial pacemaker was then inserted, and her ventricular rate became a controlled seventy-four. While a femoral arteriogram was being processed, her right lower extremity warmed and became pain-free. Normal color gradually returned to the foot. The arteriogram showed a block of the superficial femoral artery with a very poor run-off.[2] She was discharged two weeks later symptom-free with no further syncopal episodes or difficulty with her extremities.

Case Two

A seventy-four year old female was admitted to the Mercer Hospital because of a two week history of right leg pain and "cramps." In the past, she had been treated intermittently for hypertension with phenobarbital and also had been taking digitalis leaf, one-half grain every other day. On admission, blood pressure was 156/70. No pulses below a right femoral could be palpated. She was alert but in pain from a severely ischemic right leg and foot. A good left popliteal was felt with no pulses below. Bilateral carotid bruits were noted. Laboratory studies showed a hemoglobin of 12.5 Grams and a white blood cell count of 9,800 with a normal differential. B.U.N. was 14 milligrams; an F.B.S. was 92 milligrams. Serum electrolytes were within a normal range.

A right femoral arteriogram showed a superficial femoral artery block with poor run-off. Electrocardiogram disclosed complete A-V block with a rate of forty-two. A right lumbar sympathectomy was done. Her leg pain still persisted, and the foot continued to appear marginal. An endocardial pacemaker was inserted with acceleration of the ventricular rate to seventy-three. The right foot and leg became less painful and seemed to warm over the next few days. She was discharged pain-free with a viable foot three weeks after pacemaker implantation. Her carotid bruits disappeared with the neck and temporal pulses remaining.

The lower limbs of two patients were saved with the help of implantable pacemakers. Increased perfusion to the extremities by increasing cardiac output was believed to be responsible for the salvage.

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* From the Department of Surgery, The Mercer Hospital, Trenton.

433 Bellevue Avenue

NEW JERSEY DOCTORS' NOTEBOOK

Trustees' Minutes

March 16, 1969

A regular meeting of the Board of Trustees was held on March 16, 1969 at the Executive Offices in Trenton. Detailed minutes are on file with the secretary of your county medical society. A summary of the significant actions follows:

"What's Troubling Troubled Youth?" . . . Agreed to cosponsor (with no financial commitment) a symposium on "What's Troubling Troubled Youth?", to be presented by the Carrier Clinic Foundation and the Essex County Overbrook Hospital on June 15 at the Robert Treat Hotel in Newark.

AMA Conference on Physicians and Schools . . . Authorized the attendance (with expenses paid) of the Chairman of the Committee on Child Health (William J. Farley, M.D.) at the AMA sponsored National Conference on Physicians and Schools, October 9 to 11 in Chicago.

Paterson State College . . . Designated (at the request of the AMA) Dr. Joseph R. Jehl to represent the AMA at the inauguration ceremony for the incoming president of the Paterson State College in Wayne, New Jersey, on May 6.

Council on Legislation . . . Approved the report of the March 6 meeting of the Council on Legislation, including the following recommended official position of MSNJ (as amended by the Board) on bills of medical import:

S-188—To provide for the distribution of a supply of fluoridated tablets by the Department of Health where applied for by a Board of Health when any child under 9 shall request same on an application signed by the parent or guardian of the child. *DISAPPROVED,* because it is impractical of implementation, since there is in New Jersey only one county board of health established by statute—Hudson.

At its February 16 meeting the Board directed that the Council's position on S-188 be referred back to the Council on Legislation for re-consideration. The following is the Council's report.

The Council reaffirmed its position of January 1969 on S-188 for the reason set forth above. Fluoride tablets, made available under this legislation, will not be prescribed or ordered by a physician but upon the request of a parent. This seems to the Council to be in conflict with the Society's position of disapproving self-diagnosis and self-treatment on the part of the public.

S-211—To authorize the issuance of limited licenses to practice medicine and limited licenses as assistants in medicine. *DISAPPROVED,* pending consultation with the sponsors of the bill and medical schools, because we do not find this bill and its terms and elements completely clear, and because it has vital application to the standards of medical care and the public interest.

The Council named Doctors Mineur and Cunniff to act in its behalf to investigate the background of the bill in terms of its relation to the medical schools by means of a conference with the Senators who sponsored it.

S-387—To define "resident" in the act regulating rest homes for sheltered care and to provide that nothing in the act will prevent care of residents in emergency cases where the attending physician certifies that continued care is in the best interest of the resident. *APPROVED*

S-404—To provide that any person who advertises, sells, or offers any compound intended for household use which contains poisonous ingredients and does not label such package clearly is a disorderly person. *APPROVED*

S-408—To provide that the Board of Trustees of the New Jersey Medical and Dental College shall consist of 9 instead of 7 members. *NO ACTION*

S-439—To permit any person, including his insurer,
A-327—to make payment to, or on behalf of, a potential plantiff for losses or expenses resulting from any accident, without admission of liability. *APPROVED*

S-481—To provide for licensing of any applicant for a license to practice medicine and surgery who can establish he has been examined and licensed by certificate of the National Board of Examiners for Osteopathic Physicians and Surgeons. *APPROVED*

The Board referred S-481 back to the Council on Legislation for further consideration and evaluation.

S-489—To authorize hospital service corporations to include such health care services or supplies

as are approved for inclusion in their contracts by the Commissioner of Banking and Insurance. *DISAPPROVED,* because this bill would enable hospital service plans to provide medical services, a result which is invasive of the historical function of the medical service corporation and has dangerous implications to the private practice of medicine.

S-492—To permit employers of Public and School Employees Health Benefit Plan to extend benefits of fully paid health insurance to their employees after they retire. *APPROVED*

S-493—To permit public employers to extend benefits of fully paid health insurance to their employees after they retire. *APPROVED*

S-505—To authorize a bond issue, after referendum, of $100,000,000 to provide State grants-in-aid for capital construction and modernization of voluntary non-profit community hospital and related medical facilities. *NO ACTION*

S-540—To provide for appointment of two licensed practical nurses to the New Jersey Board of Nursing. *APPROVED*

SJR-10—To create a commission to study and evaluate the effectiveness of existing laws, rules, and regulations relating to the practice of all branches of the healing arts dealing with any part of the mind or body of human beings. *APPROVED*

SR-6 —To create the "Senate Special Committee on the Training of General Practitioners of Medicine and Dentistry" to inquire into what steps the State medical and dental colleges have taken to comply with legislation to prepare students for general practice in these professions. *APPROVED*

In the past, it has been the practice of the Council on Legislation to "note and file" resolutions. However, since SJR-10 and SR-6 are of significant importance to the medical profession, the Council considered them "for action" and unanimously agreed to take a position of "approved" on SJR-10 and SR-6.

A-120—To provide for commitment of convicted sex offenders; to provide for physical and mental examinations and special treatment; to provide for payment of maintenance costs by the treated person or his family. *APPROVED*

A-271—To establish a Division of Narcotic and Drug Abuse Control in the Department of Health. *APPROVED*

A-272—To provide that prepackaged meat shall be in containers which are colorless and transparent on all sides. *NO ACTION*

A-279—To increase maximum weekly Workmen's Compensation benefits for death, permanent total and temporary disability to $90; to increase maximum weekly benefits for permanent partial disability to $45 and to increase number of weeks for enucleation of an eye, 25 per cent increase in amputation awards and other changes. *NO ACTION*

A-322—To repeal the gross receipts excise tax on unincorporated businesses. *ACTIVE SUPPORT*

A-327—To permit any person, including his insurer,
S-439—to make payment to, or on behalf of, a potential plaintiff for losses or expenses resulting from any accident, without admission of liability. *APPROVED*

A-328—To provide that the name of a corporation organized under "The Professional Service Corporation Act" shall contain a name descriptive of the type of professional service in which it is engaged. *APPROVED*

A-358—To establish motor vehicle offenses for driving while under the influence of intoxicating liquor and while ability to operate a motor vehicle is impaired by consumption of alcohol, and to permit the Superintendent of State Police to issue orders from time to time to halt at random any vehicle and request the operator to submit to an analysis of his blood for alcohol and to provide penalties. *DISAPPROVED,* the medical aspects of this bill are proper, but the enforcement procedure and the penalties prescribed are much too harsh.

A-359—To provide for a penalty of imprisonment for 30 days for the first offense of operating a motor vehicle while under the influence of alcohol or drugs or where an owner lets another under such influence operate a motor vehicle. *DISAPPROVED,* the medical aspects of this bill are proper, but the enforcement procedure and the penalties prescribed are much too harsh.

The Board amended the Council's position on A-358 and A-359 to read: *"DISAPPROVED;* the medical aspects of this bill are proper, but the enforcement procedure and the penalties prescribed are an abridgement of the rights of a citizen."

A-371—To provide that any person employed in a county narcotics clinic as a psychiatric social worker and/or social worker in a narcotics clinic who assumes responsibility of the Director in his absence and attends meetings in his place and who has trained and instructed others and worked for a clinic for 18 months and with the Narcotics Commission for 5 years shall be eligible for appointment as Assistant Director. *DISAPPROVED,* because the person holding the position of assistant director of a county narcotics clinic should be a physician.

A-372—To provide that where an applicant for a nurse's license has been licensed or registered under the laws of another state, territory, possession of the United States or any foreign country, the examination shall be limited to subjects prescribed by the New Jersey Board of Nursing and not covered in the initial examination. *ACTION DEFERRED,* pending reply from the State Board of Nursing.

The Council unanimously agreed that before taking a position on this measure a letter be sent to the New Jersey State Board of Nursing asking their opinion on this bill.

A-390—To prohibit sale of motor vehicles and motorcycles which exceed prescribed noise standards. *NO ACTION*

A-392—To provide for determination of potable water standards by the Department of Health; to provide for hearings prior to adoption of such

standards; to prohibit construction of any new water supply system, pumping station, or water stoppage facility until the sanitary engineering features of plans and specifications have been reviewed and to provide for supervision of all water supply systems with respect to quality, protection, and maintenance of adequate volume. *APPROVED*

A-394—To permit the Department of Health to exempt incinerators which by type and size, in its opinion, should not be subject to the licensing requirements of the solid waste disposal act. *APPROVED*

A-446—To require ophthalmic dispensers to hold a high school diploma or equivalent in order to qualify for examination and certification. *APPROVED*

A-448—To delete the December 31, 1969 termination date applicable to prohibitory provisions concerning the practice of medicine and surgery from which exemption may be granted to doctors employed on the medical staff of a state agency. *DISAPPROVED,* because the people of the State of New Jersey should have first-class medical care under all circumstances and should not be subject to treatment by unlicensed practitioners.

The Board amended the Council's position on A-448 to read: *"DISAPPROVED,* because of the indefinite extension of time which this bill effects."

A-468—To provide that licensed psychiatrists or psychiatric social workers within a community health center shall be entitled to reimbursement for services performed under any policy of group accident, group health, or group accident and health insurance. *DISAPPROVED,* insofar as licensed psychiatrists and psychologists are concerned these bills are unnecessary, because these individuals are already entitled to reimbursement for eligible services to eligible subscribers which they render under the scope of their professional licenses. As regards psychiatric social workers these bills are undesirable because such workers are not licensed or in any other way authorized to serve as dispensers of health care services, and the bills do not include a definition to indicate what actual work a psychiatric social worker is permitted to perform.

A-471—To provide licensed practicing psychologists, psychiatrists, or psychiatric social workers within a community mental health center with reimbursement for services performed under any policy of accident and sickness insurance. *DISAPPROVED,* insofar as licensed psychiatrists and psychologists are concerned, these bills are unnecessary because these individuals are already entitled to reimbursement for eligible services to eligible subscribers which they render under the scope of their professional licenses. As regards psychiatric social workers these bills are undesirable because such workers are not licensed or in any other way authorized to serve as dispensers of health care services, and the bills do not include a definition to indicate what actual work a psychiatric social worker is permitted to perform.

A-473—to provide that benefits under any policy of accident and sickness shall not be denied any individual when services are performed by a licensed practicing psychologist, psychiatrist, or psychiatric social worker. *DISAPPROVED,* insofar as licensed psychiatrists and psychologists are concerned, these bills are unnecessary because these individuals are already entitled to reimbursement for eligible services to eligible subscribers which they render under the scope of their professional licenses. As regards psychiatric social workers these bills are undesirable because such workers are not licensed or in any other way authorized to serve as dispensers of health care services, and the bills do not include a definition to indicate what actual work a psychiatric social worker is permitted to perform.

A-479—To provide for control and abatement of noise, to create a Noise Control Council in the Department of Health; to define "noise" as "unwanted sound," and excludes all aspects of employer-employee relationship as to health and safety hazards. *APPROVED*

A-518—To provide that no dog or other animal caught or procured shall be made available for the purpose of experimentation. *DISAPPROVED,* because it would hinder progress of scientific animal research, with jeopardy to the public welfare.

A-520—To delete protective helmets from the act requiring certain equipment for motorcycle operators and passengers. *DISAPPROVED,* because protective helmets are a very necessary safety device for operators and passengers of motorcycles.

A-538—To regulate and control the sale and distribution of drugs, medicines, and poisons and the practice of pharmacy. *NO ACTION*

A-589—To create a Governor-appointed commission known as the Rutgers, South Jersey Medical and Dental College Planning Council, to choose a site for a medical-dental school in South Jersey. *APPROVED*

The Board amended the position of the Council concerning A-589 to one of *ACTIVE SUPPORT.*

Air Pollution Control Hearing . . . Approved the following statement which will be presented by MSNJ at the public hearing sponsored by the New Jersey State Department of Health, on March 26 and 27.

1. That in the planning and utilization of New Jersey's natural resources, consideration should be given to the preservation of the ecologic balance in the areas of land, air, and water.

It is suggested that ecologists, trained in environmental health, should be included in this planning and their advice given proper attention.

2. That the State Department of Health establish a Department of Environmental Health within the existing and future medical schools, with The Medical Society of New Jersey invited to cooperate.

3. That the Clean Air Division of the New Jersey State Department of Health employ a trained technician to study daily slides of specific particulate matter obtained from areas within the state in which there are large amounts of particulate fall-out. The information thus accumulated should be published and made available upon request.

4. It is necessary for the State Department of Health to assist physicians in establishing registries for the assimilation of clinical data to show the deleterious effect of air pollution on the human body.

Joint Conference of County Society Presidents . . . Discussed and exchanged questions and answers with the County Society Presidents' conference group on the following items: medical credit cards; medical practice act; inequities in negligence law affecting medical practice; Medicaid; Blue Shield ruling regarding consultations; Greater Delaware Valley Regional Medical Program; New Jersey Health Planning Commission; regional medical planning in Bergen County; second application for membership in county and state medical societies; medical-dental school for South Jersey; and MSNJ legislative activities.

Classification of Membership . . . Rescinded its previous action of January 19 referring correspondence from the Hudson County Medical Society on this subject to the Committee on Revision of Constitution and Bylaws. The matter will be presented directly to the House of Delegates in a resolution from Hudson County.

Support The
Annual Meeting Exhibits

Inspect Each One

Technical

Scientific

Informational

May 17-20 **Haddon Hall**
Atlantic City

Communicable Diseases In New Jersey

The following communicable diseases were reported to the Division of Preventable Diseases during March 1969.

	March 1969	*March 1968*
Aseptic Meningitis	14	6
Primary Encephalitis	2	4
Post-Infectious Encephalitis	0	1
Hepatitis: Total	166	164
Infectious	131	148
Serum	35	16
Malaria		
Military	14	5
Civilian	1	0
Meningococcal Meningitis	17	19
Mumps	294	460
German Measles	136	361
Measles	108	149
Salmonella	34	65
Shigella	8	23

Tetanus Toxoid Immunization

Peebles *et al.** have conducted a study on the persistency of tetanus antibody titers in 143 normal children who received three DPT or DT injections in infancy. Most of these children received a fourth dose about twelve months after completion of the first series and some had received as many as six additional boosters by the age of sixteen.

Their study showed that a fourth injection induces about an eightfold rise in antibody titer with fifth and sixth injections accounting for only about twofold rises each; further boosters induce no further significant increase in titer. The accepted protective level of tetanus antibody is 0.01 antitoxin units per milliliter of serum. The study showed that individuals receiving four or more injections of tetanus toxoid maintain protective levels for 12.3 years at the 99.9 per cent confidence level (i.e., 999 times out of 1,000).

These investigators thus recommend a series of three injections no less than one month apart in infancy; a fourth injection to complete the basic series about one year later; a fifth dose on entering school; and subsequent

* Reference: Peebles, Thomas C., Leo Levine, Mary C. Eldred, and Geoffrey Edsall: "Tetanus-Toxoid Emergency Boosters," *New England Journal of Medicine*. 280:575, March 13, 1969.

boosters once every ten years. They recommend ". . . the abandonment of other toxoid boosters as requirements for admission to camps, schools, or colleges, or for emergency administration with injuries under usual circumstances in which the history of immunization is clearly defined." Such a schedule should cut down on the presently increasing incidence of tetanus toxoid reactions, reportedly a "hyperimmune" phenomenon.

Typhoid Immunization

In three situations, the administration of typhoid vaccine might be advised: foreign travel, intimate contact with a known carrier, and a common source outbreak of typhoid. Currently there are 53 New Jersey residents considered to be typhoid carriers by the State Department of Health.

Recently, the United States Public Health Service Foreign Quarantine Program has changed the recommendation on the use of typhoid vaccine for foreign travel: "typhoid vaccine is no longer recommended for Europe, nor for other areas if the traveler stays at usual tourist accommodations."

Influenza

As reported in previous months, New Jersey experienced a sizable outbreak of viral influenza due to the A2/Hong Kong/68 virus this winter. Peak influenza morbidity was noted in late December 1968.

Beginning the second week of February 1969 a small "second wave" of influenza appeared to occur. Schools in Bergen, Burlington, Camden, Monmouth, and Atlantic Counties reported absenteeism of greater than 15 per cent due to acute respiratory-like illness. Two schools were studied serologically and several students showed significant rise in influenza B antibody titers. At least some of the late winter cases were caused by the B strain of influenza virus.

Complications of Smallpox Vaccination in the United States

During 1968 the Nationl Communicable Disease Center made a survey of complications following smallpox vaccination. During the year, some 14 million primary vaccinations and revaccinations were given. There were 510 complications as follows:

Post vaccinal encephalitis	11
Vaccinia necrosum	10
Eczema vaccination	114
Generalized vaccinia	126
Accidental infection	171
Other	78
	510

The incidence of complications was 67 per million primary vaccinations and 4.2 per million revaccinations. There were 9 deaths associated with smallpox vaccinations. Four of these were probably due to postvaccinial encephalitis and three had pre-existing disease with impairment of their immune mechanisms. Results of this survey were presented at the Annual Immunization Conference in Atlanta, Georgia on March 13, 1969.

N.J. Physician In Viet Nam With AMA Program

James R. Wiant, M.D., of Glen Gardner is in South Viet Nam serving the civilian population with the American Medical Association Volunteer Physicians for Viet Nam. Born in 1933, Dr. Wiant received his medical degree from Jefferson Medical College. He is currently assistant medical director, New Jersey State Sanatorium, Glen Gardner. Dr. Wiant explained: "I am volunteering because of my deep feeling of need for medical personnel in Viet Nam."

Volunteer Physicians for Viet Nam is administered by the American Medical Association, under contract, for the United States Agency for International Development. It is designed to use the volunteer services of U.S. physicians to assist in meeting the health needs of the Vietnamese civilian population. Under the impact of 25 years of war, health services in South Viet Nam had become inadequate to maintain the health of the peo-

ple. Of the 1,000 Vietnamese physicians, 700 are now in military service and unavailable for full time civilian practice.

About 50,000 Vietnamese civilians are treated in hospitals annually for war-related injuries. Diseases in South Viet Nam include tuberculosis, typhoid, cholera, plague, intestinal parasitism, and infectious diarrheas among children.

A continuing need exists for volunteer physicians. Particularly needed are general surgeons, orthopedic surgeons, general practitioners, and internists. Other specialists are needed from time to time. The tour of duty is 60 days. Interested physicians should write to the Volunteer Physicians for Viet Nam, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

Family Practice Residencies*

Residencies in family practice should be designed to meet the needs of graduates intending to become family physicians. The family physician is one who: (1) serves as the physician of first contact with the patient and provides a means of entry into the health care system; (2) evaluates the patient's total health needs, provides personal medical care within one or more fields of medicine, and refers the patient when indicated to appropriate sources of care while preserving the continuity of his care; (3) develops a responsibility for the patient's comprehensive and continuous health care and when needed acts as a coordinator of the patient's health services; and (4) accepts responsibility for the patient's total health care, including the use of consultants, within the context of his environment, including the community and the family or comparable social unit. In short, family physicians must be prepared to fill a unique and specific functional role in the delivery of modern comprehensive health services.

The duration of the family practice program should usually be three years following graduation from medical school. It is necessary that the family practice resident retain his identity as such throughout his graduate training program. He will need to learn appropriate skills, and procedures of certain other specialties, as well as those of family practice. Such instruction should be under the supervision of specialists in those fields. The resident's program should be planned so that he can discharge his continuing responsibilities to a selected group of patients under the supervision of experienced family physicians.

This service should include not only patients of all income levels in the general hospital but also ambulatory patients, patients at home, patients in nursing homes, and emergency care of patients. Residents assigned to the family practice service may spend a period of time outside the family medicine facility as necessary to meet the needs of his patients. Furthermore, when deemed desirable by the program director the resident may be assigned to other institutions or settings to acquire additional types of experience. This approach should help to focus attention upon the ambulatory patient, the diseases of high prevalence, patients with long-term illness, and those with problems of adjustment, anxiety, depression, and other emotional stresses. It should also facilitate emphasis upon preventive medicine, health maintenance, rehabilitation counseling, and the use of all relevant community resources.

Internal medicine functions are recognized as a major foundation for programs in family practice. The resident should receive regular instruction and gain experience which will permit him to develop judgment in assessing the condition of the patient, in use and interpretation of laboratory procedures, and in applying the principles of differential diagnosis, as well as proper therapeutic management of the patient. Emphasis should be upon the history and cause of disease and should provide the resident an opportunity to become familiar with the major causes of dis-

* Abstract of program approved by the AMA House of Delegates, Clinical Convention, December 1968.

ease and the principles of rational therapy.

There is much overlap and reinforcement between internal medicine and pediatrics, but the special contributions of pediatrics relate to the problems of the newborn, to congenital malformation, to growth and development through adolescence, to nutrition, mental retardation, and the behavioral and emotional problems of children and their management. Pediatrics includes a large component of preventive medicine and emphasizes care of the ambulatory patient and the patient at home. Pediatrics should offer opportunity for learning the diagnosis and care of infectious diseases. It should also provide study of the position of the child in the social systems of family, school, and community.

Psychiatry is a necessary basis for a family practice program. The resident should learn how to diagnose and manage most psychosomatic and emotional problems. He should become competent to deal with the common tensions, anxieties, and depressions that initiate or complicate a substantial proportion of the problems with which the family physician is faced. The resident should learn to recognize the neuroses and psychoses and to provide for the aftercare which many patients require following discharge from a mental institution.

The resident should be provided the instruction necessary to understand the biologic and psychological impact of pregnancy, delivery, and care of the newborn, upon a woman and her family. He should acquire skill in the provision of antepartum and postpartum care and the normal delivery process. He should also have an understanding of the complications of pregnancy and their management. He should become adept at managing the problems of medical and office gynecology. Marriage counseling and sex education are important areas of responsibility for the family physician.

The resident should acquire competence in recognizing surgical emergencies and when appropriate referring them for necessary specialized care, an ability to evaluate conditions that require elective surgical management, an understanding of the kinds of surgical treatment that might be employed and the problems that may result from surgical procedures and their management. He should have sufficient knowledge of these procedures to give proper advice, explanation, and emotional support to his patients. He should be trained in basic surgical principles by recognized surgical specialists and acquire from them the technical proficiency required to manage those limited surgical procedures a first contact (family) physician may be called upon to perform. If he expects to include major surgery as a part of his regular practice, he should obtain additional training.

Community medicine is one of the unique components of family practice. The resident should be provided with an understanding of epidemiology and environmental health, familiarity with the health resources of a community and community organization for health.

The experience should assist the resident to understand the role of private enterprise, voluntary organizations and government in modern health care. The social and behavioral sciences should be used to provide the resident with an understanding of the research tools and methodologies which will be of use to the family physician in discharging his integrative functions.

Symposium On Vascular Diseases

A symposium on vascular diseases is announced for May 26, 27, and 28 at the Hotel New Yorker, 34th Street and 8th Avenue, New York. The seminar is sponsored by the Montefiore Hospital and Medical Center and the Albert Einstein College of Medicine. Its aim is to present a comprehensive review of recent advances concerning diagnostic methods and therapeutic procedures for vascular diseases, and is designed to attract both the surgeon and the internist. The tuition for the three days is $100. A detailed program is available from the Symposium Chairman, Henry Haimovici, M.D., Montefiore Hospital and Medical Center, 111 East 210th Street, Bronx, New York 10467.

New Perspectives On Older Patients

"Out of all the human beings who have reached the age of 65 since the dawn of recorded history, 25 per cent are alive today."

That statement strikes with dramatic impact the first time you hear it. Yes, people are living longer and they are living better. But, many of the nation's older citizens are *not* living anywhere near their optimum for the simple reason that society has not yet been able to adjust to this phenomenon of the 20th century. Today one of every ten is 65 or older. Their situation is misunderstood by many because of the prevailing "rocking chair" or "over-the-hill" philosophy associated with the older members of society. In 1955, the AMA, recognizing the need to understand the already existing and projected needs of the rapidly rising "over 65" population and potential medical solutions, established a Committee on Geriatrics. It is now the Committee on Aging.

It then established three major goals — promotion of positive health and meaningful living among the majority of older persons who were well; encouraging long-range preventive efforts for the smaller segment of this group who were frail or fragile; and attaining the best possible health care and maximum restoration for those who were ill. We know that one ages not because of the mere passage of time, but because of what happens *in* time, as opposed to another view that aging is irreversible because cells are "programed" for so many cell divisions.

Members of the committee soon found themselves involved with such non-medical matters as housing, retirement, family life, and economics — all of which bear intimately on the health of older people.

The nine-member committee and its staff have worked with a number of other national organizations, including the American Association of Retired Persons, which numbers more than a million members keenly aware of problems and needs.

Among the major areas of the committee's interest is the matter of mandatory retirement. Its view is that "compulsory retirement is a waste of human resources that this nation can ill afford . . . it contributes measurably to ill health resulting from lack of work, exercise and responsibility."

The committee's efforts also have encouraged an increasing number of physicians to follow its outline for a periodic health appraisal in examining older patients. This appraisal, in addition to being a complete medical and personal history by systems, also includes a mental and emotional evaluation, dietary history, history of physical exercise and recreation, and also a social chronology as a parallel to present illness, thus illuminating any pyschosomatic relationships which may exist, and to correct certain "borderline" tendencies that may point to potential future trouble.

The committee now is studying the plight of older citizens whose automobile insurance may be arbitrarily canceled merely because they have attained a certain age. The committee hopes to develop crisp medical standards of driving competence in older individuals and to encourage physicians to apply these standards for their older patients, thus influencing insurance companies to recognize such standards in formulating underwriting requirements.

You will be interested in the following Committee on Aging publications. You can get them from the AMA in Chicago:

"How Adults Can Improve and Maintain Their Health"

"Outline for a Periodic Health Appraisal"

"The Chronic Illness Newsletter" (bimonthly)

"More Life for Your Years" (monthly fact sheet)

"Guides for Medical Society Committees on Aging"

"A New Concept of Aging"

"Health Promotion for Adults"

"Retirement, A Medical Philosophy and Approach"

"Needs of the Long-Term Patient"

What Is A Psychiatrist?

The following brochure was developed by the New York State Branch of the American Psychiatric Association. At the instruction of the Board of Trustees of The Medical Society of New Jersey, this material is here reprinted.

The Role of the Psychiatrist in Mental Health

A new era prevails in the aims, availability, and level of health care. It is being geared to provide adequate services and facilities to all without compromise of quality and without social or economic class distinction.

The achievement of adequate care in the field of mental health is one of the crucial challenges of this era. In order to benefit all persons who need such care, the full range of knowledge, techniques, and services of every professional in general medicine, psychiatry, and the related helping professions will be demanded. The latter include psychologists, social workers, psychiatric nurses, and other mental health personnel.

Many persons are puzzled by certain basic questions in realm: What is a psychiatrist? a psychologist? a social worker? What professional standards and requirements must they meet in preparing for their work? How can their skills be used most effectively in the public interest?

What is a Psychiatrist?

The psychiatrist is first a physician and second, a medical specialist in the field of mental, psychological, and emotional disorders. These range from minor or mild problems in living, family life, and work on through the spectrum of life's difficulties, including those severe disabilities tht are generally identified as major mental illnesses.

What Training Does a Psychiatrist Have?

The psychiatrist-to-be attends college, generally for four years. He usually majors in the physical and behavioral sciences, including psychology and sociology, and graduates with a bachelor's degree. Then come four years of medical school training. There, his studies embrace such basic sciences as biochemistry, anatomy, pharmacology, and physiology as well as clinical training and experience in surgery, internal medicine, pediatrics, gynecology and obstetrics, neurology, developmental psychology, psychiatry, and other areas of medical practice. He participates as a physician in the entire cycle of human life, suffering, and experience, from prenatal care to death. Those are the minimum essentials that prepare him to diagnose and treat human illness — physical, psychological, and emotional — and that qualify him for an M.D. degree.

Next, the physician serves as an intern in an accredited general hospital for not less than one year. That is an intensive, full-time working experience with patients. He functions as their physician under the supervision of more experienced colleagues. Subsequently, he must pass rigorous examinations in order to become a licensed physician and to practice medicine. Those examinations are conducted by medical boards that are accredited on a state or national level.

To become a specialist in any area of medical practice, he must engage in further hospital training at a university medical center or an accredited teaching hospital, where he serves as a resident physician in the area of his choice. A resident physician in psychiatry must devote at least three years of full-time work in such a setting. Some programs extend through fourth and fifth years.

The resident psychiatrist learns to use all of the available methods in treating mental and emotional disorders of adults, adolescents, and children in hospital and clinic settings. He also learns to make specific and accurate diagnoses — the key to all treatment. There is particular emphasis on the diagnosis and treatment of neurological illnesses (diseases of the brain, spinal cord, and nerves) as well as of medical conditions that have symptoms similar to those of psychiatric illnesses (for example, thyroid, heart, and gastrointestinal disease). Finally, the resident participates in coordinating all the facilities of the hospital, including the collaborative efforts of other medical specialists and ancillary personnel, for the ultimate benefit of the patient.

Psychiatric Treatment Methods

During his training and experience, the psychiatrist learns to use a broad spectrum of treatment methods and techniques. As new approaches are introduced, he becomes proficient in utilizing them to promote the health and welfare of the patients. The principal methods in current use are:

Pyschotherapy: There are several kinds, including individual, group, family, psychoanalytic, behavioral, conditioning, and others.

Drug Therapy: A large variety of tranquilizing and antidepressant drugs has become increasingly available during the past decade. They may be prescribed only by a licensed physician and administered under his supervision. The use of those drugs has increased and enhanced the effective range of treatment in hospital, clinic, and office practice. Their use has been significantly responsible for the remarkable decrease in the populations of our mental hospitals through the avoidance of hospitalization for many psychiatric illnesses and the shortening of the average period of inpatient care when hospital treatment becomes necessary.

Milieu Therapy: The environment of the hospital and the community mental health center includes a number of programs (day and night hospitals and others) that facilitate the socialization process of patients. Such programs help to overcome withdrawal, isolation, loneliness, and fear of social contact as well as to promote and encourage socially constructive behavior.

Rehabilitative Therapies: These include vocational guidance, training, and adjustment, occupational and recreational therapy, sheltered workshops, and others.

Physical Treatments: In carefully selected situations, patients benefit by the administration of electroshock treatments as well as by narcosynthesis ("truth serum").

The physician has full medical responsibility for the patient even when parts of the prescribed treatment program are carried out by other members of the mental health team. Unless there is a physician, there is no medical responsibility, and the patient's condition may be inadequately diagnosed or treated.

Post-College Educational Requirements for Psychiatrists, Psychologists, and Social Workers

Psychiatrists	*Clinical Psychologists*	*Social Workers*
DEGREE: M.D. (Doctor of Medicine). Required: Four years of medical school with substantial supervised clinical experience in addition.	DEGREE: Ph.D. (Doctor of Philosophy in Psychology) representing at least three years of full time graduate study.	DEGREE: M.S.W. (Master of Social Work) is the usual degree requirement representing at least two years of graduate course study, one of which normally consists of supervised field experience.
MEDICAL INTERNSHIP: Required for psychiatrists. Entails at least one year of supervised clinical experience in an accredited hospital.	PSYCHOLOGICAL INTERNSHIP (non-medical): Required for Ph.D. Represents one additional predoctoral year of full-time work in a variety of settings, providing supervised experience in research and service.	INTERNSHIP: None.
LICENSURE: Required: A state license to practice medicine is issued after successful completion of examination by a state board of medical examiners.	LICENSURE OR CERTIFICATION: Most states regulate the practice of psychology, some by licensure and some by certification by state boards. In some other states non-statutory certification is provided by the state psychological association.	LICENSURE OR CERTIFICATION: In some states social workers are registered or certified under state licensing statutes for social workers.
RESIDENCY: Three years of full-time specialty training and supervised experience in an accredited psychiatric hospital or department.	RESIDENCY: None.	RESIDENCY: None.
DIPLOMATE IN PSYCHIATRY: Three years of approved residency plus two additional years of psychiatric practice are minimal requirements for admission to oral and written examinations by the American Board of Psychiatry and Neurology. Those who pass the examinations become Diplomates in Psychiatry.	DIPLOMATE IN PSYCHOLOGY: The American Board of Examiners in Professional Psychology offers a Diplomate in Clinical Psychology. Minimal requirements are five years of post-Ph.D. experience and successful completion of oral and written examinations.	DIPLOMATE: None as such. However, the Academy of Certified Social Workers issues certificates to qualified social workers who have completed at least two years of supervised experience beyond the M.S.W. requirement.

What is Psychotherapy?

The literal meaning of psychotherapy is "treatment of the mind." It refers to the use of verbal therapeutic techniques — often combined with the use of drug, physical, environmental, and other methods — to assist the patient with a mental or emotional disorder to alleviate his symptoms, and to help him become a healthier member of the community.

Psychotherapy, like all medical therapy, is based upon (1) a diagnosis that differentiates a patient's illness from other possible illnesses; and (2) an appropriate treatment plan chosen from the entire range of available therapeutic methods, including drug and other therapies that only the physician can prescribe. The knowledge and techniques derived from psychoanalysis can play an important role in the formation of such a plan.

The Current Pattern of Psychiatric Practice

Most psychiatrists, until recent years, devoted their time primarily to work in mental hospitals or in private practice. Now, ongoing studies disclose that the majority of psychiatrists spend a significant portion of their time participating in activities in the medical and the general community. As members of the attending staffs of general hospitals and of the teaching staffs of medical schools, they are engaged in the care of psychiatric patients in the hospital and the clinic, in providing consultation to other services, and in teaching and supervising medical students, interns, and psychiatric residents. In addition, they participate in programs for nonpsychiatric physicians, nurses, and other hospital personnel that are designed to clarify the role of emotions in human behavior and in response to illness. Another area of involvement is the research investigation of the origins of emotional illnesses, of the effectiveness of various treatments, and of teaching and training methods. In the broader community, psychiatrists are involved in consultation and treatment programs in the schools, courts, welfare and social agencies, police departments, homes for the aged, and nursing homes, and also in the development and growth of community mental health centers and programs.

Today's psychiatrist aims to make his services as varied and as widespread as possible, establishing meaningful and continuing collaboration with workers

in the health services as well as in mental health. Thus, the psychiatrist, cognizant of the range of health needs and the facilities designed to meet them as well as being well-versed in his own field, is better equipped than ever to provide the full range of mental health treatment methods to individual patients and their families.

Differences in Professional Training

The educational requirements of psychiatrists differ from those of psychologists and social workers. The qualifications for each of these professional groups are summarized in the accompanying table (see centerfold).

What Should a Troubled Person do to Obtain Help?

The family physician is the best-qualified person to oversee health problems, and one should begin by consulting him. If psychiatric treatment is needed, the physician will be able to make a proper referral because of his knowledge of the mental health resources in the community. One may also consult the telephone directory for the number of the local medical society, psychiatric or mental health association, or the department of psychiatry of a local hospital. They are all prepared to help.

Quackery in Weight Reduction

The American Medical Association recently told Congress that weight reduction is a leading health area for quackery.

The AMA position on weight reduction (particularly with reference to diet pills) was outlined by Dr. Theodore B. Van Itallie of New York City, a member of the Council on Foods and Nutrition, and Dr. Harry C. Shirkey of Alabama, vice chairman of the Council on Drugs. They spoke before the Senate Antitrust and Monopoly Subcommittee.

The subcommittee was investigating reports that some M.D.s were making large incomes from assembly-line administration of multicolored "diet" pills containing barbiturates, thyroid extract, amphetamines, thiazine, diuretics, laxatives, and various hormones. Officials of Illinois and Oregon testified that such pills were involved in at least 20 deaths in their states.

"Perhaps in no other area of health and medical problems do we encounter as much food faddism and quackery," Dr. Van Itallie testified. "The obese are extremely gullible, forever willing to believe that someday a gadget, a diet, a pill, or a book will lead to easy and painless reduction of weight. While most of the quackery originates with unqualified health hucksters, a physician is occasionally involved.

"The American Medical Association has long utilized its publications to bring to the profession and the public up-to-date information on the latest scientific advances in the area of obesity control. It frequently focuses attention upon those irregular practitioners and faddists who prey upon the unsuspecting public. As the national voice of medicine, it is incumbent upon us to help protect the public from those practices which have the potential of adversely affecting the public health. . . .

"A physician who assumes the responsibility for treating obesity takes on a difficult role. Few other medical disorders require the same disciplined and prolonged cooperation of the patient in their treatment. Even under the best of circumstances, the results of treatment become apparent slowly. The inherent handicaps may strain the busy physician's patience and tempt him to resort to unsound methods of treatment. He must have a clear understanding of the physiologic and psychologic problems of obesity in order to treat it wisely."

Dr. Shirkey broke down weight control drugs into seven general classifications: (1) cardiac glycosides; (2) hormones, chiefly thyroid; (3) diuretics; (4) anorexiants (appetite suppressants); (5) laxatives; (6) sedatives; and (7) antispasmodics. Of them he said:

Cardiac glycosides: "Their use for obesity is reprehensible and may well have attributed to the deaths of patient receiving such treatment."

Thyroid: "There are at least three irrationalities in this hormonal approach to the treatment of obesity."

Diuretics: "There is no rational basis for using diuretic drugs in the treatment of simple obesity."

Anorexiants: "Amphetamines are useful as a crutch to help the patient become accustomed to a rigorous reducing diet. But long-term administration is not justified because they tend to become less effective and, in addition, can lead ultimately to habituation."

Laxatives: "There is little rational basis for the use of laxatives in the treatment of obesity."

MEETINGS OF MEDICAL INTEREST

This listing has been compiled by the Academy of Medicine of New Jersey. For additional information, including exact time of meetings, write to the society or hospital listed.

May

6 **Hudson County Medical Society**
Election of Officers

7 **Bergen Pines County Hospital**
Division of Internal Medicine
Paramus
"Present Day Treatment of Chronic Renal Disease"

7 **New Jersey Association of School Physicians**
Labor Education Center, Rutgers
New Brunswick
"Sports Medicine"

8 **Essex County Medical Society**
Annual Meeting

13 **Bergen County Medical Society**

14 **Mercer County Medical Society**
State Hospital
Trenton

14 **Ocean County Medical Society**

15 **Gloucester County Medical Society**

15 **Morris County Medical Society**

17-20 **MSNJ Annual Meeting**
Haddon Hall
Atlantic City

18 **The Academy of Medicine of New Jersey**
Atlantic City
Haddon Hall
Symposium: "The Diagnosis of Life and Death"

20 **Warren County Medical Society**

21 **Bergen Pines County Hospital**
Division of Internal Medicine
Paramus
"Adrenalcortical Insufficiency"

21 **The Academy of Medicine of New Jersey**
Mountainside Hospital
Montclair
Symposium: "Diseases of the Lung"

22 **Essex and Morris County Medical Societies with Sandoz Pharmaceuticals**
Sandoz Auditorium
Hanover
"Genetic Factors Affecting Drug Response"

23 **The Academy of Medicine of New Jersey**
Hotel Robert Treat
Newark
Annual Awards Dinner

26 **Cape May County Medical Society**

27 **Hunterdon County Medical Society**

28 **Middlesex County Medical Society**

June

4 **New Jersey Diabetes Association and New Jersey Department of Health**
Hunterdon Medical Center
Flemington
Symposium: "Diabetes"

10 **Bergen County Medical Society**

10 **Cumberland County Medical Society**

11 **Middlesex County Medical Society**

11	**Ocean County Medical Society**	17	**Warren County Medical Society**
12	**Mercer County Medical Society** Trenton Country Club Trenton Annual Outing	19	**Gloucester County Medical Society**
		19	**Morris County Medical Society**

OBITUARIES

Dr. Samuel Baum

At the grand age of 85, Samuel Baum, M.D., died on March 28, 1969. He was a 1907 graduate of the Long Island College of Medicine, and enjoyed more than a half century of family practice. In 1957 he was a laureate of our Medical Society's Golden Merit Award. Dr. Baum was one of the founders of the Essex County Anatomic and Pathologic Society. In 1963, at the age of 79, he retired from active practice and became an emeritus member of our Essex County Medical Society.

Dr. Francisco Cantanzaro

At the age of 72, Francisco Cantanzaro, M.D. died on February 25, 1969. Dr. Cantanzaro received his M.D. degree in 1921 at the University of Palermo in Italy. He was a general surgeon, identified with the Beth Israel Hospital in Passaic, where he was an associate gynecologic surgeon. Dr. Cantanzaro was, until some years ago, active in committee work with the Passaic County Medical Society.

Dr. Julius S. Heller

Born in Russia in 1886, Julius Heller was brought to the United States in 1891. He was a member of the class of 1910 at the New York University (Bellevue) Medical School. A general practitioner, he established interest and skill in the field of genito-urinary surgery. He was active in Ocean County's medical and civic affairs. In his later years, he became interested in geriatrics and in chronic diseases. Dr. Heller died on February 25, 1969.

Dr. Hugh A. McLean

At the 1969 Annual Meeting Hugh Alexander McLean, M.D., was scheduled to receive the Golden Merit Award. He will not be there, for he died on March 10, 1969, in the 74th year of a useful and busy life. His M.D. came from Northwestern in 1919, and he was surgeon at St. Mary's Hospital in Hoboken. Dr. McLean was a Fellow of the American College of Surgeons and practiced in West New York. He was active in the affairs of the Hudson County Medical Society.

Dr. Robert L. Silich

Death came to Robert L. Silich, M.D., on March 31, 1969, at the untimely age of 60. He was a well-known Hudson County practitioner, who received his M.D. at Bellevue in 1936. Shortly after completion of his internship he was commissioned a first lieutenant in the Army of the United States and was later promoted to captain. He served to the very end of the conflict in 1946. Dr. Silich was a family doctor, affiliated with the Christ Hospital in Jersey City, and maintained his office for private general practice in Union City.

Dr. Richard D. Swain

Dick Swain was one of the pioneers in cranial surgery in this state. Born in 1894, he earned his M.D. at Vanderbilt in 1917, and was immediately commissioned in the medical corps. On being mustered out, he did graduate work in otologic surgery, and was in on the ground floor in the development of cranial surgery in the early 1920s. He became the attending or consulting neurosurgeon in hospitals from Dover to Newark, and almost all points in between. Thus, full of honors, in the 75th year of his useful life he died on March 18, 1969.

BOOK REVIEWS

Suicidal Behaviors. Edited by H. L. Resnick, M.D. (48 authors) Boston, 1968, Little, Brown. Pp. 536. ($15)

This editor appeals to everybody. Here is an anthology for clergymen, nurses, social workers, teachers, and physicians. It contains essays by 48 different authors, strung together like beads on a string, with no effort to integrate them or write passages to smooth the flow between chapters. Some material on drug treatment (with the advice to give tranquilizers to already depressed patients!) will be found in a chapter on hospital management, some in a chapter on somatotherapy, some in the chapter on biochemical research, and some in a chapter on pharmacotherapy. Perhaps this kind of cross-purpose writing is inevitable in a book by four dozen authors. The index can't keep pace with all this, so that if you look under *drugs* you will find some references; under *tranquilizers* some more; and under *pharmacotherapy* some additional ones.

The doctor wants to know under what circumstances he might be held negligent if his patient commits suicide. There *is* a chapter on "legal aspects" but this doesn't tell the doctor what his liability is. There is no index listing under liability or under "malpractice," though there is one under *Moon, phases of and suicide.*

An 85 page section is devoted to several suicide preventing or anticipating community agencies -- though one wonders whether a page and a half should be wasted in spot-mapping the locations of the 75 branches of Samaritans in England.

The book contains several unique chapters. There is interesting material on suicide by means of victim-precipitated homicide. Murphy and Robins have an essay on the communication of suicidal ideas. Space is given to the prediction of suicide and appraisal of the suicide risk. Viewed as a whole, this book is a sort of one-volume encyclopedia of the subject.

HENRY A. DAVIDSON, M.D.

Textbook of Otolaryngology. 3rd Edition. David D. DeWeese, M.D.; William H. Saunders, M.D. St. Louis, 1968, Mosby. Pp. 457. With 396 Illustrations. ($11.50)

This textbook is intended for medical students and general practitioners. It is a basic work in the field of otolaryngology with emphasis on diagnosis and with a superficial but inclusive discussion of treatment. However, with this third edition, the authors have added material on some of the newer surgical technics such as mediastinoscopy, endolymphatic shunt for Ménière's disease, the use of silicone rubber prostheses in facial plastic surgery, and the treatment of blow-out fractures of the orbital floor. They have up-dated their discussion of stapedectomy for otosclerosis. Also added, have been work sheets for tracheotomy care and newer illustrations of laryngeal structures.

DeWeese and Saunders offer an up-to-date rendition of basic material in the broadening field of otolaryngology. The student and the general physician who desires a broad, but not too detailed, discussion of common ear, nose, and throat problems will certainly benefit from this book. It is elementary yet comprehensive. It is readable and amply illustrated. As the authors intended, the book is an excellent, and should be a popular, introductory otolaryngology text.

RAYMOND B. STRAUSS, M.D.

Anesthesia for Infants and Children. 3rd Edition. Robert M. Smith, M.D., St. Louis, 1968, Mosby. Pp. 530. Illustrated. ($17.50)

Dr. Smith has accomplished something that very few medical writers are capable of doing; he has managed to cover in a very up-to-date fashion a large subject matter in a comprehensive and yet extremely readable fashion. His experience is apparent from the wealth of detail which he has incorporated in this book. Yet he makes it completely understandable even to those not in his specialty.

The first part of the book deals with the basic requirements; biology, physiology, and other necessary fundamentals of his subject. He follows this with a discussion of different types of anesthesia, and drugs used along with the anesthetic agents.

The next several chapters of the book are devoted to anesthesia for the subspecialties of surgery. If nothing else, we recommend a surgeon reading that chapter devoted to his particular specialty. It certainly makes clear the necessity for good rapport between anesthesiologists and surgeons. The final short chapter deals with the legal aspects of pediatric anesthesia, and, although brief, is of great interest.

We consider this book an essential requirement for anyone in or entering upon the specialty of anesthesiology, and recommend it to all surgical specialists.

LEO J. KELLY, JR., M.D.

Communicable and Infectious Diseases. Edited by Franklin Top, M.D. Ed. 6. St. Louis, 1968, Mosby. Pp. 755. With 135 illustrations, many in color ($28.50)

In this sixth edition of a popular textbook, 39 distinguished experts thoroughly review the subject. The printing is attractive and readable, the binding sturdy, the index convenient, and the price good value.

The fifty-three separate chapters are up-to-date, concise yet complete and authoritative. The editor properly balanced chapter size against relative importance of subject and avoided the usual trap of uneven writing from many authors. All the chapters are well-done and readable. The illustrations, some in color, are excellent.

The first 114 pages cover infection, immunity, host factors, epidemiology, government regulations, immunization, isolation and quarantive technics that are goldmines of useful facts, and concepts. The 60 pages devoted to drug therapy should be read by every doctor and will pay handsome dividends for the time invested every working day thereafter. The remainder of the book refers to specific diseases. In this era of rapid change, of new diseases, of new drugs and new tests, this book will help the busy practitioner bring current knowledge to his patient's problems. It is highly recommended for purchase, to be read completely and as a standard shelf reference for day-to-day clinical questions. This reviewer considers it the best in its field.

NORMAN RIEGEL, M.D.

Use of Interpretation in Treatment. Edited by E. F. Hammer, Ph.D. New York, 1968, Grune and Stratton. Pp. 379. ($16.75)

Last year, Hobbs said that, "he had come to doubt the presumed relationship between the achievement of insight and the achievement of more effective functioning. . . . I began to wonder why we never examined the alternate explanation of the failure of insight to produce changes in behavior . . . that insight may have nothing to do with behavior change at all. . . ." He cites as explanations three arguments: The stress on timing of interpretations; the good results obtained with play therapy with children where no insight is attempted; the equipotentiality of diverse interpretations . . . suggesting that the occurrence of an insight merely means that the client is catching on to the therapist's personal system for interpreting the world of behavior. Hobbs' charges continue: "The Therapist does not have to be right; he mainly has to be convincing." He sees interpretation as serving to chase one symptom away in favor of another.

Hammer here responds to Hobbs' indictment by defending interpretation with many meaningful examples and explanations of its usefulness. On his defense roster are many eloquent proponents of the use of interpretation covering many schools of thought.

One of the most interesting papers is by Rosalea Ann Schonbar, "Confessions of an Ex-Nondirectivist."

Snyder points out that many times self-examination is a process of circular mislogic, and the same errors may be repeated if there is no intervention from a therapist to start the thinking process along a new channel. Other aspects of interpretation here covered include the need for positive transference before interpretation can be effective; the value of an "inexact interpretation;" the need for attenuation when the therapist feels he has gone too rapidly and allowing for later acceptance. The book contains many interesting papers, including one on "Interpretation In Psychotherapy With Adolescents" and another called "Interpretation In Group Psychotherapy."

This is a thought-provoking book whose contributors have provided 43 interesting papers covering many schools of therapy and attitudes about what interpretation is, how it can be best accomplished, and what its value is in therapy. LILLIAN BRUNELL, M.A.

Cell Differentiation (Ciba Foundation Symposium). Edited by A.V.S. De Reuck and Julie Knight. Boston, 1968, Little, Brown and Company. Pp. 257. Illustrations 43. ($12.00)

This book, representing another volume in the Ciba Foundation Symposia series, offers (as have the previous volumes) material in basic medical science presented in a scholarly manner. The papers are given by world leaders and cover cell differentiation from "Single Cell Properties — Membrane Development" (the first paper) through "Interaction of Tumour and Embryonic Tissue *in Vivo*" (the last paper). In between are eleven fascinating papers concerned with biochemical changes during development, feedback regulation of hematopoiesis, mechanisms of information transfer between groups of cells, chemical nature of embryonic inducers, masking of genes in carcinogenesis and maintenance of tumors as organized structures in vitro. The illustrations are well chosen and informative. They consist mostly of optical photomicrographs with only one electron micrograph and several drawings.

In the preface it is stated, "If more questions are raised than answered in this symposium, we feel that this may be in itself a fruitful contribution to progress in this vital field." I agree with both propositions and the questions raised are at once interesting and thought provoking.

This book is valuable reading for anyone concerned with this remarkable biologic process. I recommend it for thoughtful reading to all physicians who want to understand the language of the basic medical science of tomorrow. HUGH F. LUDDECKE, M.D.

Health of Mankind (Ciba Foundation Symposium). Edited by Gordon Wolstenholme and Maeve O'Connor. Boston 1967, Little, Brown. Pp 297. Illustrated. ($12.00)

The Ciba Foundation presents a sober, intriguing, and wide-ranging discussion of the ills that beset mankind, together with thoughtful and considered "solutions." The participants are world-renowned physicians, biologists, agriculturalists, engineers, and ecologists.

Important problems on the agenda are brought in from all areas of this unhealthy globe: the major communicable diseases (measles still kills one-half million children a year), mother-child care, cancer and cardiovascular disease, population growth, nutrition, environmental pollution, and manpower resources.

A statistician would probably be delighted. Graphs, charts, and tabular figures abound. They are clear and appropriate.

Although the price of $12.00 seems high, this book would be of interest to any practitioner who has a general interest in health problems beyond that of the patient at hand. LEO LEWIN, M.D.

Tumors of the Large Bowel. Raymond J. Jackman, M.D. and Oliver H. Beahrs, M.D. Vol. III in the Series: Major Problems in Clinical Surgery. Philadelphia, 1968, Saunders. Pp. 379. Illustrated. ($13.50)

Major Problems in Clinical Surgery deals with the most common of tumors in patients in the Western World—large intestine neoplasms. Jackman and Beahrs have drawn upon the vast experience of the Mayo Clinic and the English speaking literature to set in perspective a succinct modern approach to the management of benign, premalignant, and malignant conditions of the anus and large intestine. Saunders has been most successful in reproducing twenty-four brilliant color plates of characteristic lesions.

The chapters dealing with the diagnostic and differential diagnostic aspects and the management of the complex subject of polyps is the strongest section in the book. The authors set forth an extensive, detailed, and systematic consideration of *common* and *uncommon polyps.*

Benign and malignant tumors of the colon and rectum, premalignant and malignant lesions of the anus, and current surgical considerations in the management of large bowel tumors are updated in polished presentations in this text. The recommendations of the authors will be of interest to all surgeons working in this field. Residents, proctologists, colon and rectal, as well as general surgeons will find this volume to be of daily practical value. STANLEY S. FIEBER, M.D.



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Indication—Oral contraception.

Contraindications—Thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia, undiagnosed abnormal genital bleeding.

Warnings—Watch for the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism, retinal thrombosis); if present or suspected discontinue the drug immediately.

British studies reported in April 1968[1,2] estimate there is a seven- to tenfold increase in mortality and morbidity due to thromboembolic diseases in women taking oral contraceptives. In these controlled retrospective studies, involving 36 reported deaths and 58 hospitalizations due to "idiopathic" thromboembolism, statistical evaluation indicated that the differences observed between users and non-users were highly significant. The conclusions reached in the studies are summarized in the table below:

Comparison of Mortality and Hospitalization Rates Due to Thromboembolic Disease in Users and Non-Users of Oral Contraceptives in Britain.

Category	Mortality Rates		Hospitalization Rates (Morbidity)
	Age 20-34	Age 35-44	Age 20-44
Users of Oral Contraceptives	1.5/100,000	3.9/100,000	47/100,000
Non-Users	0.2/100,000	0.5/100,000	5/100,000

No comparable studies are yet available in the United States. The British data, especially as they indicate the magnitude of the increased risk to the individual patient, cannot be applied directly to women in other countries in which the incidences of spontaneously occurring thromboembolic disease may differ.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or sudden onset of proptosis, diplopia or migraine. Withdraw medication if papilledema or retinal vascular lesions are found.

Since the safety of Ovulen in pregnancy has not been demonstrated, it is recommended that pregnancy be ruled out for any patient who has missed two consecutive periods before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the first missed period.

A small fraction of the hormone agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

Precautions—Pretreatment physical examination should include special reference to the breasts and pelvic organs, and a Papanicolaou smear.

Endocrine and possibly liver function tests may be affected by Ovulen. Therefore, it is recommended that such tests if abnormal be repeated after the drug has been withdrawn for two months.

Pre-existing uterine fibromyomas may increase in size under the influence of progestogen-estrogen preparations.

Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation.

In breakthrough bleeding, and all irregular vaginal bleeding, consider nonfunctional causes. Adequate diagnostic measures are indicated in undiagnosed vaginal bleeding.

Carefully observe patients with a history of psychic depression and discontinue the drug if severe depression recurs.

Any possible influence of prolonged Ovulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study.

A decrease in glucose tolerance has occurred in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be observed carefully while receiving Ovulen.

Because of the effects of estrogens on epiphyseal closure Ovulen should be used judiciously in young patients in whom bone growth is not complete.

The age of the patient constitutes no absolute limiting factor, although Ovulen therapy may mask the onset of the climacteric.

The pathologist should be informed of Ovulen therapy when relevant specimens are submitted.

Adverse Reactions—A statistically significant association has been shown between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: cerebrovascular accidents, neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement, secretion), change in weight, changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, allergic rash, rise in blood pressure in susceptible individuals, mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme and nodosum, hemorrhagic eruption, itching.

The following laboratory results may be altered by oral contraceptives: hepatic function: increased sulfobromophthalein and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T^3 uptake values; metyrapone test; pregnanediol determination.

References: 1. Inman, W. H. W., and Vessey, M. P.: Brit. Med. J. 2:193-199 (April 27) 1968. 2. Vessey, M. P., and Doll, R.: Brit. Med. J. 2:199-205 (April 27) 1968.

Before prescribing see Detailed Product Information.

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Often the symptoms of anxiety states are difficult to sort out—even with the most careful probing. The patient may manifest symptoms of agitation, restlessness, insomnia, somatic complaints. But what of the depression that may be mixed in the total picture? It is reassuring to know that Mellaril may be prescribed—with strong possibilities of success—when there is anxiety alone or a mixture of anxiety and depression.

Before prescribing or administering, see Sandoz literature for full product information, including adverse reactions reported with phenothiazines. The following is a brief precautionary statement.

Contraindications: Severe central nervous system depression, comatose states from any cause, hypertensive or hypotensive heart disease of extreme degree.

Warnings: Administer cautiously to patients who have previously exhibited a hypersensitivity reaction (e.g., blood dyscrasias, jaundice) to phenothiazines. Phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides. During pregnancy, administer only when necessary.

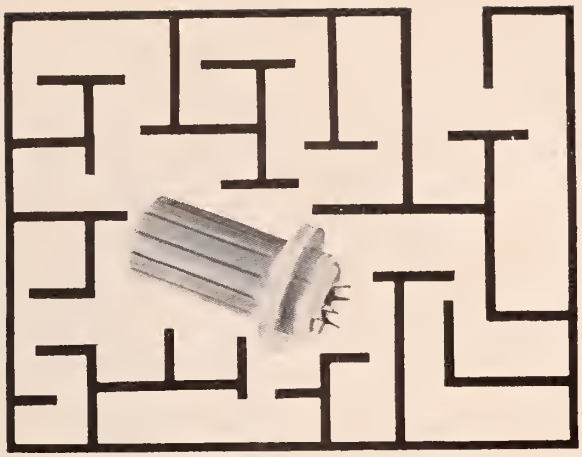
Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy may be avoided by remaining within the recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving). Orthostatic hypotension is more common in females than in males. Do not use epinephrine in treating drug-induced hypotension. Daily doses in excess of 300 mg. should be used only in severe neuropsychiatric conditions.

Adverse Reactions: *Central Nervous System*—Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomic Nervous System*—Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System*—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin*—Dermatitis and skin eruptions of the urticarial type, photosensitivity. *Cardiovascular System*—Changes in the terminal portion of the electrocardiogram have been observed in some patients receiving the phenothiazine tranquilizers, including Mellaril (thioridazine hydrochloride). While there is no evidence at present that these changes are in any way precursors of any significant disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients previously showing electrocardiographic changes. The use of periodic electrocardiograms has been proposed but would appear to be of questionable value as a predictive device. *Other*—A single case described as parotid swelling.

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To lower blood pressure
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For brief summary of prescribing information, see next page.

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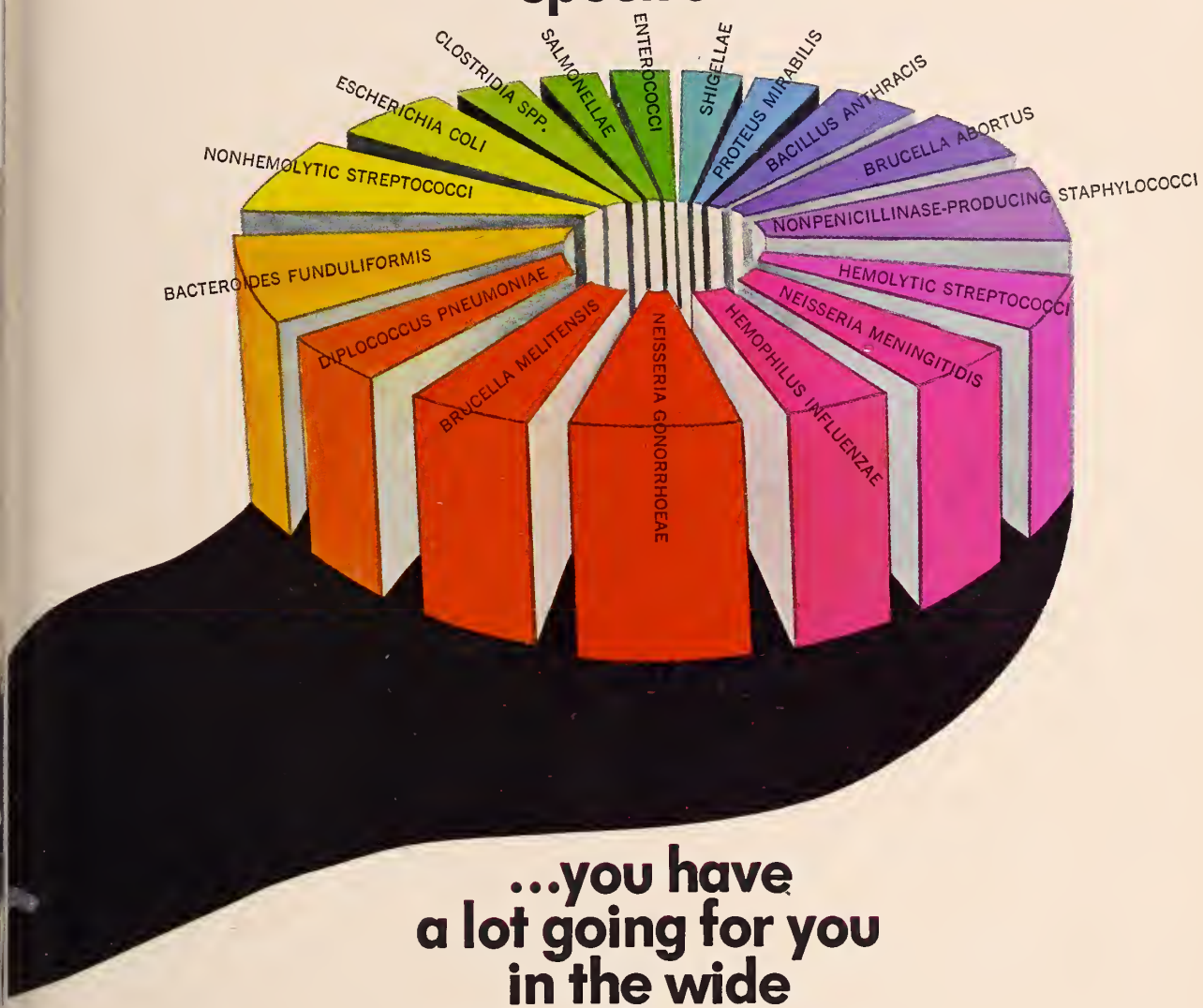
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Indications: Hypertension.
Contraindications: History of mental depression, hypersensitivity, and most cases of severe renal or hepatic diseases.
Warning: With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small-bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has frequently been required and deaths have occurred. Discontinue coated potassium-containing formulations immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur. Discontinue one week before electroshock therapy, and if depression or peptic ulcer occurs.
Use in pregnancy: Because chlorthalidone may cross the placental barrier and appear in cord blood and thiazides may appear in breast milk, this drug should be used with care in pregnant patients and nursing mothers. When used in women of childbearing age, the potential benefits of the drug should be weighed against the possible hazards to the fetus. Use of chlorthalidone may result in fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult. Increased respiratory secretions, nasal congestion, cyanosis and anorexia may occur in infants born to reserpine-treated mothers.
Precautions: Antihypertensive therapy with this drug should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents, other potent antihypertensive drugs, or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. To avoid hypotension during surgery, discontinue therapy with this agent two weeks prior to elective surgical procedures. In emergency surgery, use, if needed, anticholinergic or adrenergic drugs or other supportive measures as indicated. Because of the possibility of progression of renal damage, periodic kidney function tests are indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated. Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, the drug should be discontinued and potassium supplements given, provided the patient does not have marked oliguria.
Take particular care in cirrhosis or severe ischemic heart disease and in patients receiving corticosteroids, ACTH, or digitalis. Severe salt restriction is not recommended. Use cautiously in patients with ulcerative colitis or gallstones (biliary colic may be precipitated). Bronchial asthma may occur in susceptible patients.
Adverse Reactions: The drug is generally well tolerated. The most frequent side effects are nausea, gastric irritation, vomiting, diarrhea, constipation, muscle cramps, headache, dizziness and acute gout. Other potential side effects include angina pectoris, anxiety, depression, bradycardia and ectopic cardiac rhythms (especially when used with digitalis), drowsiness, dull sensorium, hyperglycemia and glycosuria, hyperuricemia, lassitude, restlessness, transient myopia, impotence or dysuria, orthostatic hypotension which may be potentiated when chlorthalidone is combined with alcohol, barbiturates or narcotics, leukopenia, aplastic anemia, skin rashes, thrombocytopenia, agranulocytosis, nasal stuffiness, increased gastric secretions, nightmare, purpura, urticaria, ecchymosis, weakness, uveitis, optic atrophy and glaucoma, and pruritus. Eruptions and/or flushing of the skin, a reversible paralysis agitans-like syndrome, blurred vision, conjunctival injection, increased susceptibility to colds, dyspnea, weight gain, decreased libido, dryness of the mouth, deafness, anorexia, and pancreatitis when epigastric pain or unexplained G I. symptoms develop after prolonged administration. Jaundice, xanthopsia, paresthesia, photosensitization and necrotizing angiitis are possible.
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Availability: Pink, single-scored tablets in bottles of 100 and 1000.
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PRESCRIBING INFORMATION. For complete information consult Official Package Circular. **Indications:** Infections due to susceptible strains of Gram-negative bacteria (including Shigellae, *S. typhosa* and other Salmonellae, *E. coli, H. influenzae, P. mirabilis, N. gonorrhoeae* and *N. meningitidis*) and Gram-positive bacteria (including streptococci, pneumococci and nonpenicillinase-producing staphylococci). **Contraindications:** A history of allergic reactions to penicillins or cephalosporins and infections due to penicillinase-producing organisms. **Precautions.** Typical penicillin-allergic reactions may occur, especially in hypersensitive patients. Mycotic or bacterial superinfections may occur. Experience in newborn and premature infants is limited and caution should be used in treatment, with frequent organ function evaluations. Safety for use in pregnancy is not established. In gonorrheal therapy, serologic tests for syphilis should be performed initially and monthly for 4 months. Assess renal, hepatic and hematopoietic function intermittently during long-term therapy. **Adverse Reactions:** Skin rash, pruritus, urticaria, nausea, vomiting, diarrhea and anaphylactic reactions. Mild transient elevations of SGOT or SGPT have been noted. Black tongue has been noted in some patients receiving the Chewable Tablets. **Usual Dosage:** Adults—250 or 500 mg. q. 6 h. (according to infection site and offending organisms). Children—50-100 mg./Kg./day in 3 to 4 divided doses (depending on infection site and offending organisms). Bacterial meningitis —150-200 mg./Kg./day in 6 to 8 divided doses. Children weighing more than 20 Kg. should be given an adult dose when prescribing orally. In parenteral administration, children weighing more than 40 Kg. should be given an adult dose. Beta-hemolytic streptococcal infections should be treated for at least 10 days. **Supplied:** Capsules—250 mg. in bottles of 24 and 100. 500 mg. in bottles of 16 and 100. For Oral Suspension—125 mg./5 ml. in 60, 80 and 150 ml. bottles. 250 mg./5 ml. in 80 and 150 ml. bottles. Chewable Tablets—125 mg. in bottles of 40. Injectable—for I.M./I.V. use—vials of 125 mg., 250 mg., 500 mg., and 1 Gm. Pediatric Drops—100 mg./ml. in 20 ml. bottles.

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Precautions: Exercise caution in moderate to severe hepatic disease. Elderly or debilitated patients may react with marked excitement or depression.

Adverse Reactions: Drowsiness at daytime sedative dose levels, skin rashes, "hangover" and systemic disturbances are seldom seen.

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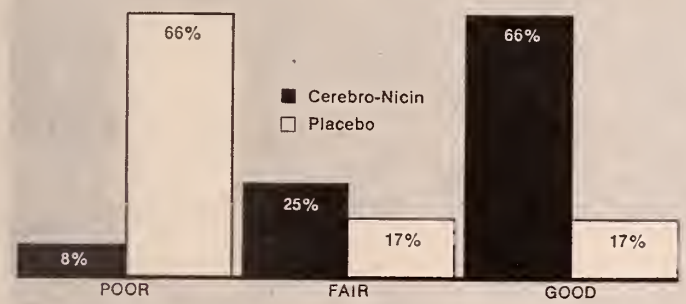
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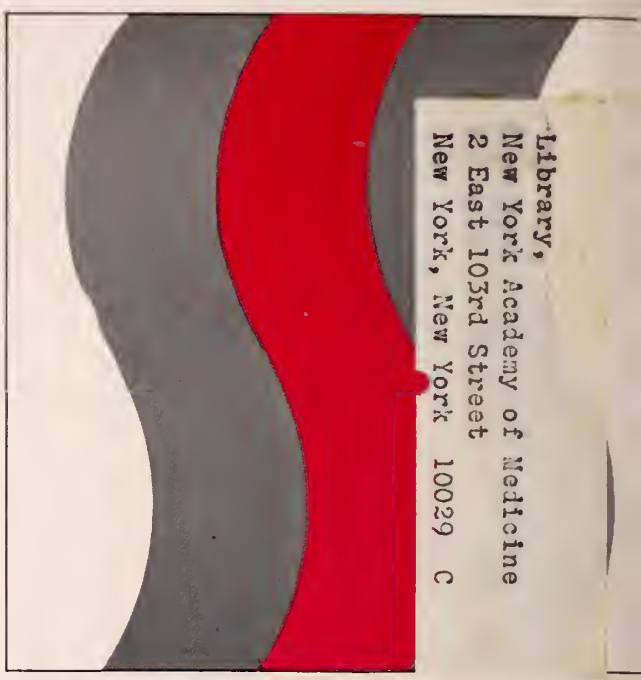
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BALCONY

the JOURNAL
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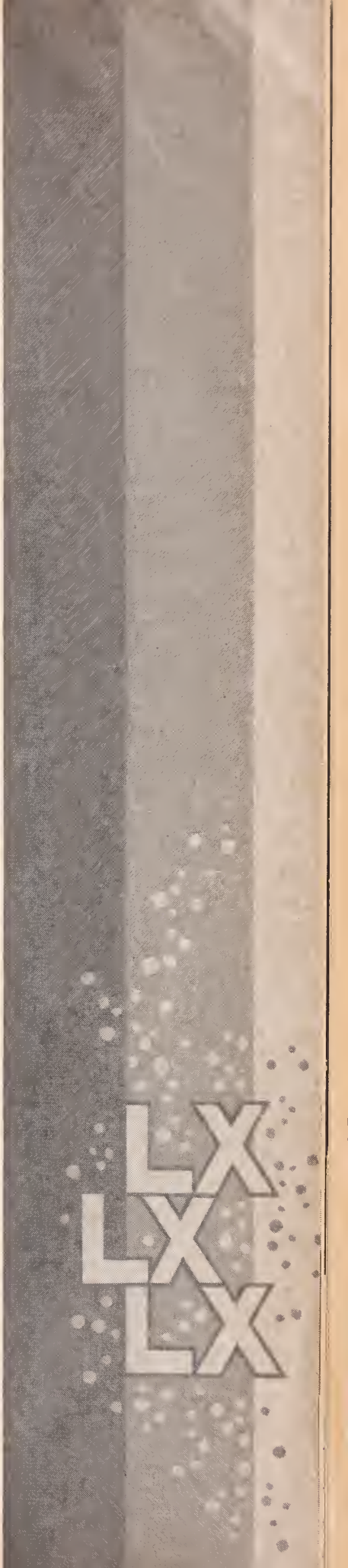
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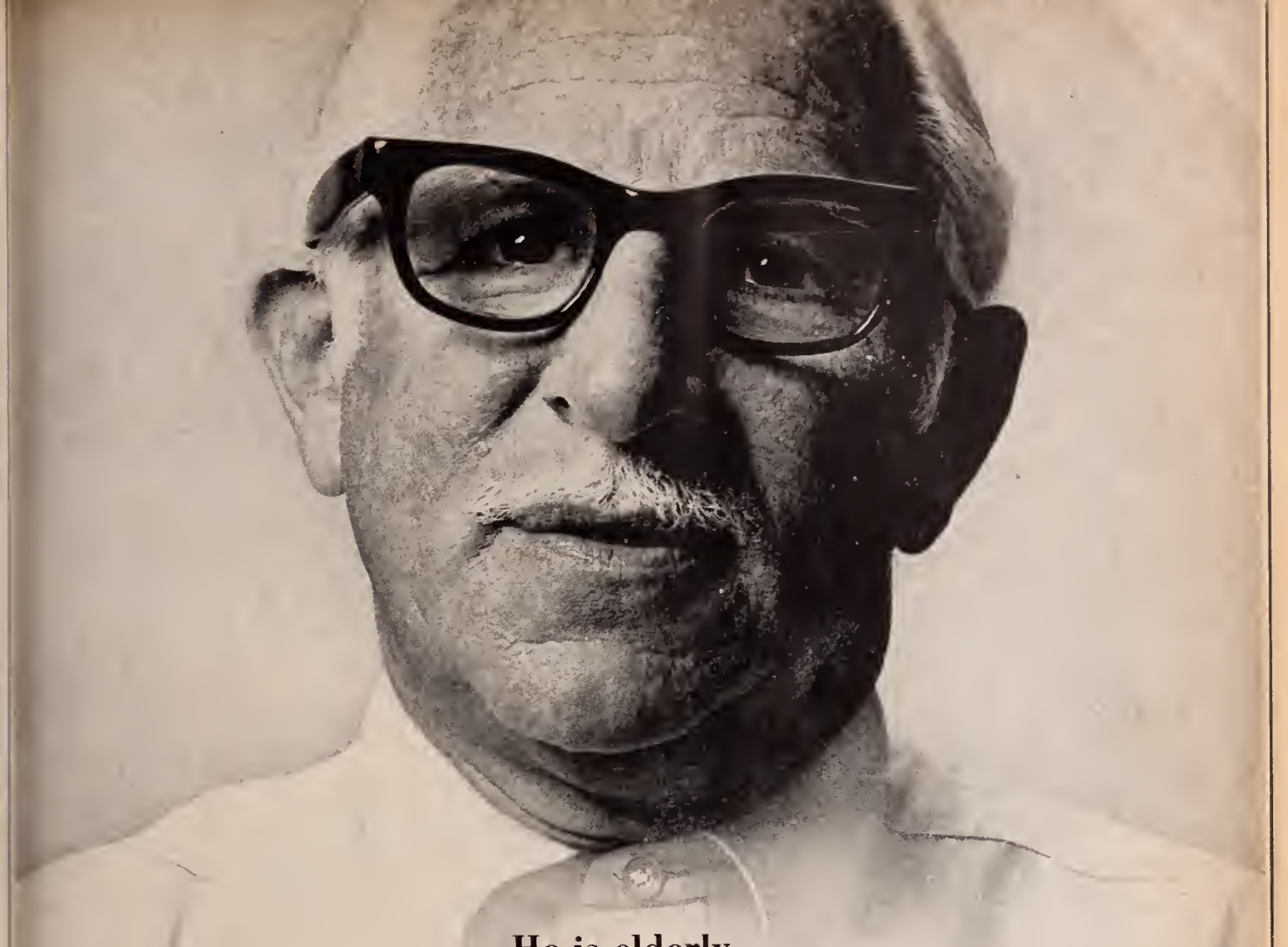
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He is elderly.
He is on corticosteroids.
When he needs an antibiotic
he may be a candidate for

DECLOSTATIN® 300

Demethylchlortetracycline HCl 300 mg
and Nystatin 500,000 units
CAPSULE-SHAPED TABLETS Lederle

b.i.d.

To guard susceptible patients against intestinal monilial overgrowth during broad-spectrum therapy—the protection of nystatin is combined with demethylchlortetracycline in DECLOSTATIN.

For your susceptible candidates, prescribe DECLOSTATIN—the broad-spectrum therapy that prevents monilial overgrowth.

Effectiveness: Because its antibacterial component is DECLOMYCIN Demethylchlortetracycline, DECLOSTATIN should be equally or more effective therapeutically than other tetracyclines in infections caused by tetracycline-sensitive organisms. The antifungal component, Nystatin, protects against superinfection by antibiotic-resistant fungal overgrowth (particularly monilia) in the intestinal tract.

Contraindication: History of hypersensitivity to demethylchlortetracycline or nystatin.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

Lederle

LEDERLE LABORATORIES
A Division of American Cyanamid Company, Pearl River, New York

345-B



For the "Cheater Eater"

Formulas: Each 'Dexamyl' *Spansule* capsule No. 1 contains 10 mg. of Dexedrine® (brand of dextroamphetamine sulfate) and 1 gr. of amobarbital, derivative of barbituric acid (Warning, may be habit forming). Each 'Dexamyl' *Spansule* capsule No. 2 contains 15 mg. of Dexedrine (brand of dextroamphetamine sulfate) and 1½ gr. of amobarbital (Warning, may be habit forming).
Before prescribing, see complete prescribing information in SK&F literature or *PDR*.
Contraindications: Hyperexcitability, undue restlessness, hyperthyroidism, porphyria; in patients on MAO inhibitors.
Precautions: Use with caution in patients hypersensitive to sympathomimetics or barbiturates and in coronary or cardiovascular disease or severe hypertension. Excessive use of the amphetamines by unstable individuals may result in a psychological dependence. Rarely, symptoms of toxic psychosis (hallucinations, confusion, panic states, etc.) may occur with amphetamines, usually after prolonged high dosage. In these instances, withdraw the medication. Use cautiously in pregnant patients, especially in the first trimester.
Adverse Reactions: Overstimulation, restlessness, insomnia, g.i. disturbances, diarrhea, palpitation, tachycardia, elevated blood pressure, tremor, sweating, impotence and headache.
Supplied: In bottles of 50.

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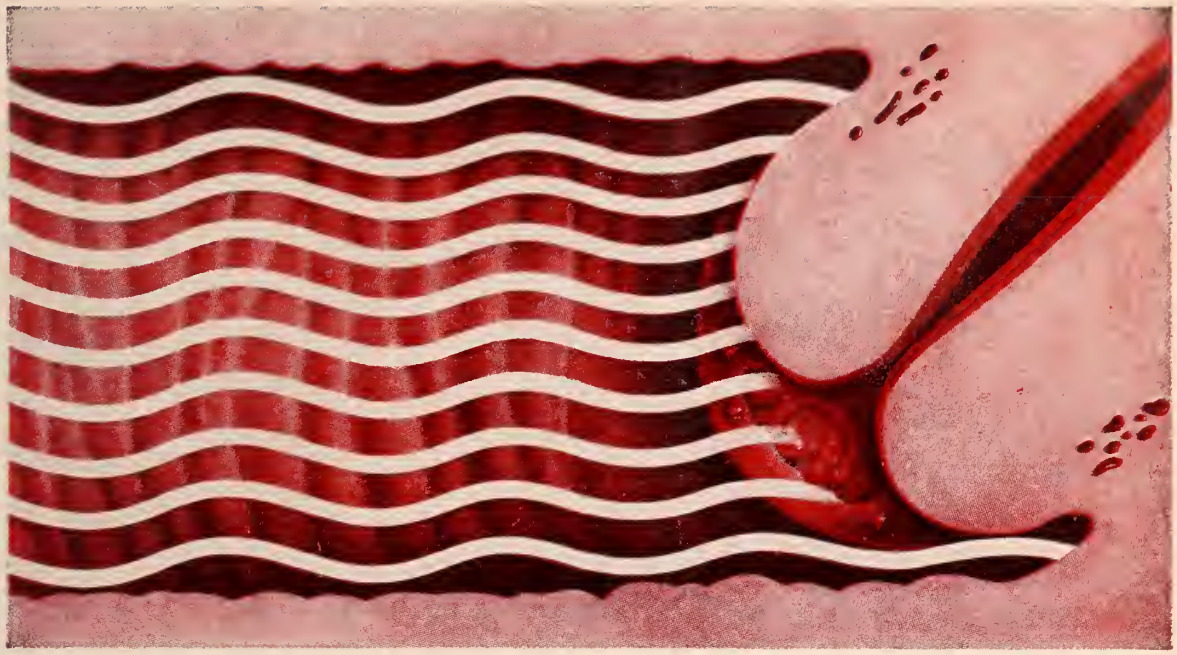
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brand of sustained release capsules

curbs appetite
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dispels diet discouragement

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Contains: Sodium perborate, sodium bicarbonate, sodium chloride, sodium borate, menthol, thymol, eucalyptol, methyl salicylate and aromatics—Bottles of 6 oz., 15 oz., 32 oz., Cartons of 12, 10 Gm. Packets

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"Yes. Patients respond well to it, and seem to take it more faithfully."

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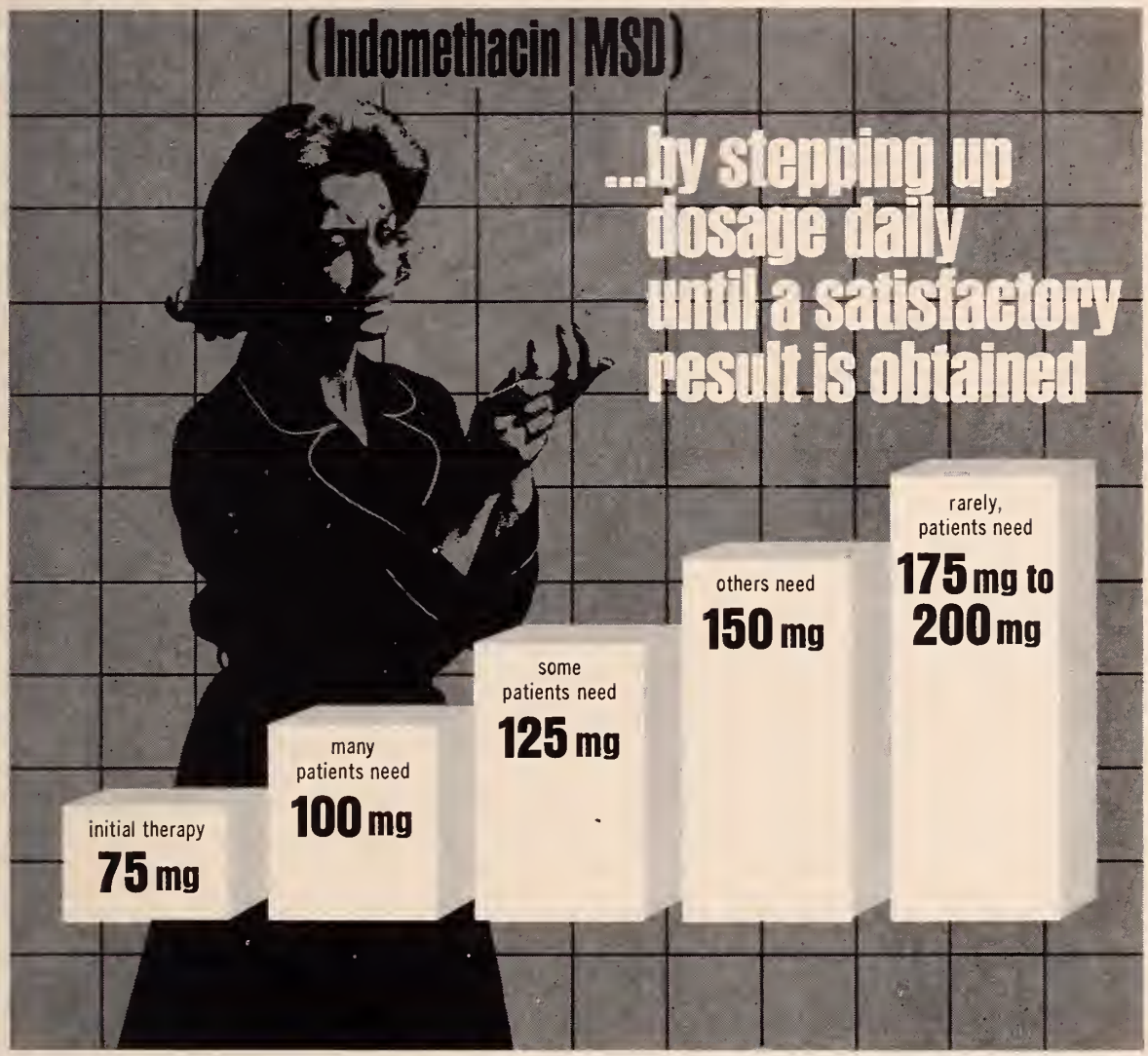
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Fort Washington, Pa. 19034

In selected cases of rheumatoid arthritis with acute symptoms

Response to INDOCIN® is often improved...

(Indomethacin | MSD)



Many patients with acute rheumatoid arthritis or acute episodes of chronic rheumatoid arthritis can be controlled by increasing the dosage 25 mg *per day* (to the allowable maximum) until the episode subsides; the dosage should then be reduced gradually to maintenance levels. Few require the maximum (175–200 mg).

In the event the patient develops adverse effects, dosage should be reduced to tolerated levels for 2 or 3 days and then gradually increased by 25 mg every few days as tolerated. G.I. effects may be minimized by giving INDOCIN with food, antacids, or immediately after meals.

Now in two strengths
25 mg and 50 mg



Actual Size

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(Indomethacin | MSD)

IMPORTANT NOTE: INDOCIN (Indomethacin, MSD) cannot be considered a simple analgesic and should not be used in conditions other than those recommended under *Indications*. The drug should not be prescribed for children because safe conditions for use have not been established.

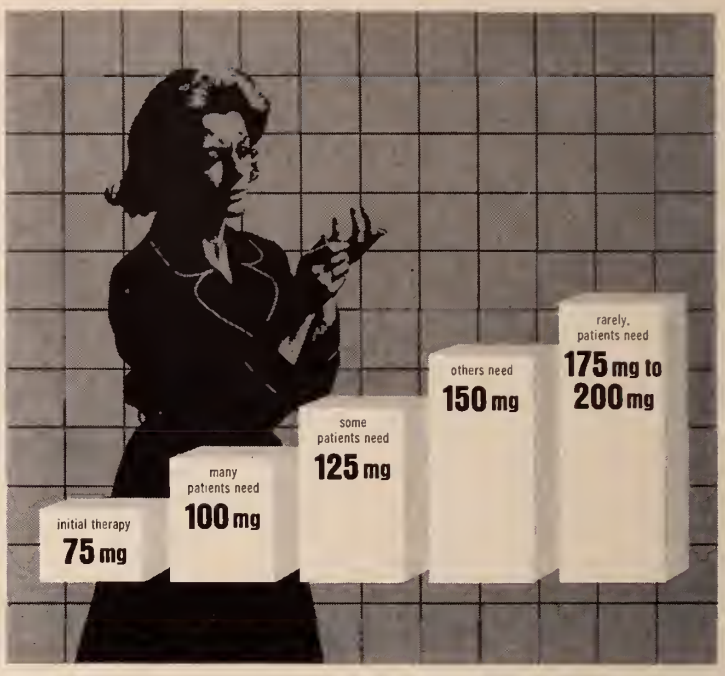
CONTRAINDICATED:

- in aspirin-sensitive asthmatics
- during pregnancy or lactation
- in children
- INDOCIN may mask the signs and symptoms of peptic ulcer and may cause ulceration or irritation of the G.I. tract. Therefore, do not give in active peptic ulcer, gastritis, regional enteritis, ulcerative colitis, and use with caution if there is a history of these disorders.

For additional prescribing information, please see following page.

In selected cases
of rheumatoid arthritis
with acute symptoms

Response to INDOCIN® (Indomethacin | MSD) is often improved by stepping up dosage daily until a satisfactory result is obtained



IMPORTANT NOTE: INDOCIN (Indomethacin, MSD) cannot be considered a simple analgesic and should not be used in conditions other than those recommended under Indications. The drug should not be prescribed for children because safe conditions for use have not been established.

Indications: For the symptomatic treatment of rheumatoid arthritis, rheumatoid (ankylosing) spondylitis, degenerative joint disease (osteoarthritis) of the hip, and gout.

Contraindications: INDOCIN may mask the signs and symptoms of peptic ulcer and may itself cause peptic ulceration or irritation of the G.I. tract. For these reasons it should not be given to patients with active peptic ulcer, gastritis, regional enteritis, or ulcerative colitis (use with caution if there is history of these disorders); aspirin-sensitive asthmatics. Safe use during pregnancy or during lactation has not been established. Should not be prescribed for children because safe conditions for use have not been established. In a few cases of severe juvenile rheumatoid arthritis receiving INDOCIN along with other drugs, severe reactions, including fatalities, have been reported.

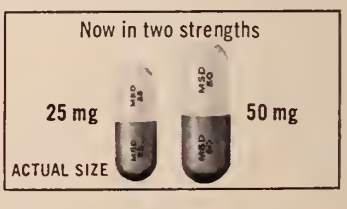
Warnings: Patients who experience dizziness, lightheadedness, or feelings of detachment on INDOCIN should be cautioned against operating motor vehicles or machinery, climbing ladders, etc. Use cautiously in patients with psychiatric disturbances, epilepsy, or parkinsonism since it may aggravate these conditions.

Precautions: Use cautiously in patients with a history of peptic ulcer, gastritis, regional ileitis, or ulcerative colitis because of its potential for causing G.I. bleeding. May cause single or multiple ulceration of the esophagus, stomach, duodenum, or small intestine, and, in a few Instances, severe bleeding and perforation with a few fatalities have been reported. May potentiate the ulcerogenic effect of steroids, salicylates, or phenylbutazone. Gastrointestinal bleeding with no obvious ulcer formation has also been noted; the drug should be discontinued if G.I. bleeding occurs. As a result of obvious or occult G.I. bleeding, some patients may manifest anemia, and for this reason periodic hemoglobin determinations are recommended. G.I. effects may be minimized by giving the drug with food or with antacids or immediately after meals. In common with other drugs that have anti-inflammatory, analgesic, and antipyretic properties, indomethacin may mask the signs and symptoms of infection; avoid undue delay in initiating appropriate treatment of the infection; use cautiously in patients with existing, but controlled, infections. As with any new drug, patients should be followed carefully to detect unusual manifestations of drug sensitivity.

Adverse Reactions: Starting therapy with low doses, with gradual increases when necessary, will minimize adverse reactions. *Central Nervous System:* Most commonly, headache (usually more severe in morning), dizziness, and lightheadedness; infrequently observed reactions include mental confusion, drowsiness, convulsions, coma, depression, and other psychic disturbances, such as depersonalization; CNS effects are often transient and frequently disappear with continued treatment or reduced dosage. The severity of these effects may occasionally require cessation of therapy. *Gastrointestinal:* Most commonly, nausea, anorexia, vomiting, epigastric distress, abdominal pain, and diarrhea; others that may develop are ulceration, single or multiple, of esophagus, stomach, duodenum, or small intestine, including perforation and hemorrhage with a few fatalities having been reported; G.I. bleeding without obvious ulcer formation, increased abdominal pain in patients with preexisting ulcerative colitis; less commonly, stomatitis; gastritis; bleeding from the sigmoid colon, occult in type or from a diverticulum, and perforation of preexisting sigmoid lesions (diverticulum, carcinoma); G.I. reactions not known definitely to be attributable to indomethacin include development of ulcerative colitis and of regional ileitis. *Hepatic:* Rarely, jaundice and hepatitis. *Cardiovascular-Renal:* Infrequently, edema, elevation of blood pressure, and hematuria. *Dermatologic-Hypersensitivity:* Infrequently, pruritus, urticaria, angioneurotic edema, angiitis, skin rashes, loss of hair, and acute respiratory distress including sudden dyspnea and asthma. *Hematologic:* Infrequently, leukopenia, purpura, and thrombocytopenia; rarely, agranulocytosis and bone marrow depression have been reported, but a definite relationship to the drug has not been established; since some patients may manifest anemia secondary to obvious or occult G.I. bleeding, periodic hemoglobin determinations are recommended. *Eye-Ear:* Infrequently, tinnitus, blurred vision, hearing disturbance, and orbital and periorbital pain. *Miscellaneous:* Rarely, vaginal bleeding, hyperglycemia, and glycosuria.

Supplied: Capsules containing 25 mg indomethacin each, in bottles of 100 and 1000; capsules containing 50 mg indomethacin each, in bottles of 100.

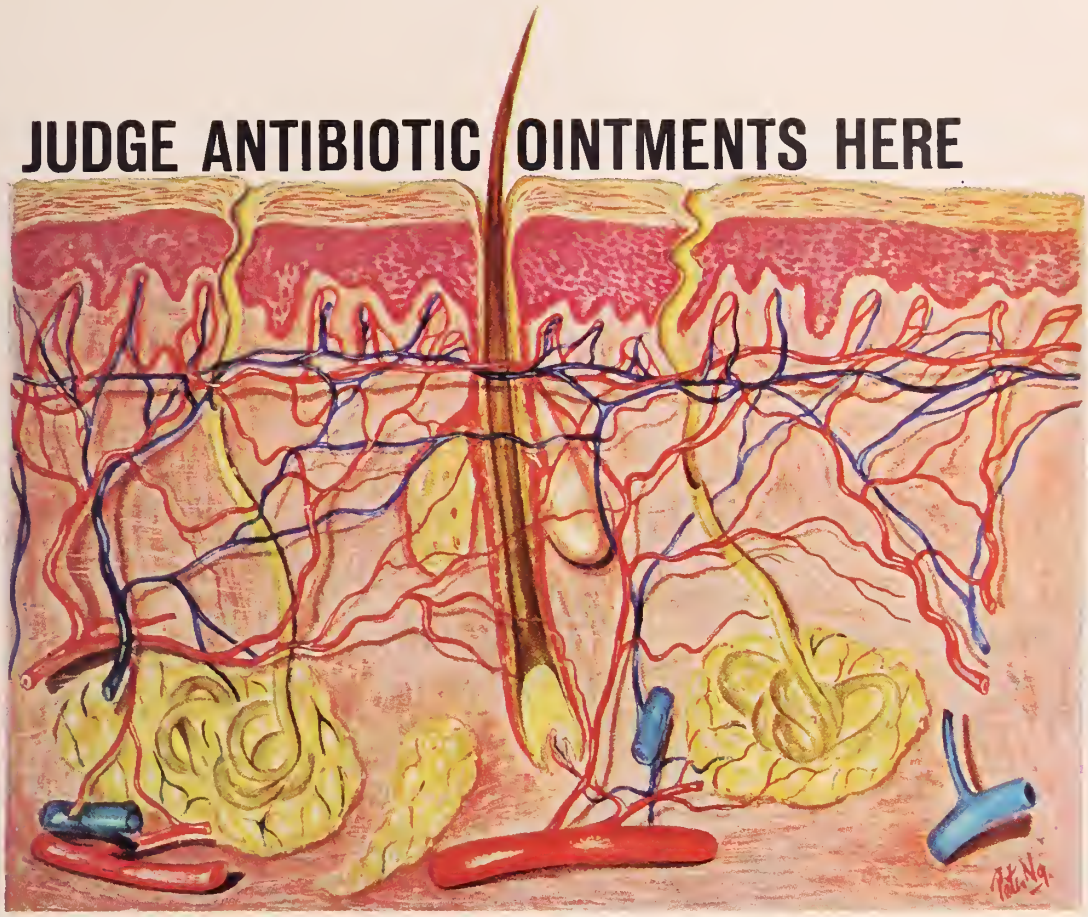
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WHERE TODAY'S THEORY IS TOMORROW'S THERAPY

JUDGE ANTIBIOTIC OINTMENTS HERE



Results on skin are final proof of any topical antibiotic's effectiveness

No in vitro test can duplicate a clinical situation on living skin. 'Neosporin' (polymyxin B—bacitracin—neomycin) Ointment has consistently proven its effectiveness in thousands of cases of bacterial skin infection. The spectra of the three antibiotics overlap in such a way as to provide bactericidal action against most pathogenic bacteria likely to be found topically. Diffusion of the antibiotics from the special petrolatum base is rapid since they are insoluble in the petrolatum, but readily soluble in tissue fluids. The Ointment is bland and nonirritating.

Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Contraindications: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

Supplied: Tubes of 1 oz., ½ oz. with applicator tip, and ⅛ oz. with ophthalmic tip.

Complete literature available on request from Professional Services Dept. PML.

'NEOSPORIN'®

brand

POLYMYXIN B-BACITRACIN-NEOMYCIN OINTMENT

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.

Mild ulcerative colitis may be triggered here...



In mild ulcerative colitis, a number of factors can precipitate an attack: for instance, dietary indiscretion, such as eating raw foods, or emotional overreaction, such as that aroused by financial difficulties. No matter what causes the patient's sensitive colon to "act up," he soon suffers from acute discomfort...and often, from anxiety and apprehension as well. Such patients frequently respond well to adjunctive dual-action Librax® therapy.

Librax combines, in a single convenient capsule, the well-known antianxiety effect of Librium® (chlordiazepoxide HCl) and the dependable anticholinergic /antispasmodic effect of Quarzan® (clidinium Br). Therefore, as Librax helps to relieve the patient's excessive anxiety and reduce his overreaction to stress, it also, at the same time, helps to control hypersecretion and hypermotility, thus relieving spasm and abdominal discomfort.

With Librax, the dosage schedule is simple: 1 or 2 capsules, t.i.d. or q.i.d., will in most cases bring the patient significant relief of both the emotional and physical elements that contribute to his psychovisceral disorder.

Before prescribing, please consult complete product information, a summary of which follows.

INDICATIONS: Indicated as adjunctive therapy to control emotional and somatic factors in gastrointestinal disorders.

CONTRAINDICATIONS: Patients with glaucoma; prostatic hypertrophy and benign bladder neck obstruction; known hypersensitivity to chlordiazepoxide HCl and/or clidinium bromide.

WARNINGS: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering Librium (chlordiazepoxide hydrochloride) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards. As with all anticholinergic drugs, an inhibiting effect on lactation may occur.

PRECAUTIONS: In elderly and debilitated, limit dosage to smallest effective amount to preclude development of ataxia, oversedation or confusion (not more than two capsules per day initially; increase gradually as needed and toler-

or here.



ted). Though generally not recommended, if ombination therapy with other psychotropics eems indicated, carefully consider individual harmacologic effects, particularly in use of po- entiating drugs such as MAO inhibitors and henothiazines. Observe usual precautions in resence of impaired renal or hepatic function. aradoxical reactions (*e.g.*, excitement, stimula- on and acute rage) have been reported in psy- hiatric patients. Employ usual precautions in reatment of anxiety states with evidence of im- ending depression; suicidal tendencies may be resent and protective measures necessary. Vari- ble effects on blood coagulation have been eported very rarely in patients receiving the rug and oral anticoagulants; causal relation- hip has not been established clinically.

ADVERSE REACTIONS: No side effects or anifestations not seen with either compound lone have been reported with Librax. When hlordiazepoxide hydrochloride is used alone, rowsiness, ataxia and confusion may occur, specially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally with chlordiazepoxide hydrochloride, making periodic blood counts and liver-function tests advisable during protracted therapy. Adverse effects reported with Librax are typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy and constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics, and/or low residue diet.

two good reasons for prescribing

LIBRAX®

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

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LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110



Nose clear as a whistle

(THANKS TO DIMETAPP®)

Dimetapp Extentabs® does an outstanding job of helping to clear up the stuffiness, drip and congestion of colds and upper respiratory allergies and infections. Each Extentab keeps working up to 12 hours. And for most patients drowsiness or overstimulation is unlikely. Try Dimetapp. It clearly works.

FOR UPPER RESPIRATORY ALLERGIES AND INFECTIONS

Dimetapp Extentabs®

Dimetane® (brompheniramine maleate), 12 mg.; phenylephrine HCl, 15 mg.; phenylpropanolamine HCl, 15 mg.

UP TO 12 HOURS CLEAR BREATHING ON ONE TABLET

Indications: Dimetapp is indicated for symptomatic relief of the allergic manifestations of respiratory illnesses, such as the common cold and bronchial asthma, seasonal allergies, sinusitis, rhinitis, conjunctivitis, and otitis.
Contraindications: Hypersensitivity to antihistamines. Not recommended for use during pregnancy.
Precautions: Until patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care to patients with cardiac or peripheral vascular diseases or hypertension.
Side Effects: Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia, have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered.
Dosage: 1 Extentab morning and evening.
Supplied: Bottles of 100 and 500.

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That's just the problem. A mother's love tells her her children need milk. Real milk. But who tells a mother why?

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You can tell her that milk and the other dairy foods provide over 75% of the calcium in the American food supply. Calcium for bone strength. And protein (the kind that contains all the essential amino acids) for soft tissue growth and maintenance.

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With it, you can help add a little understanding to love.

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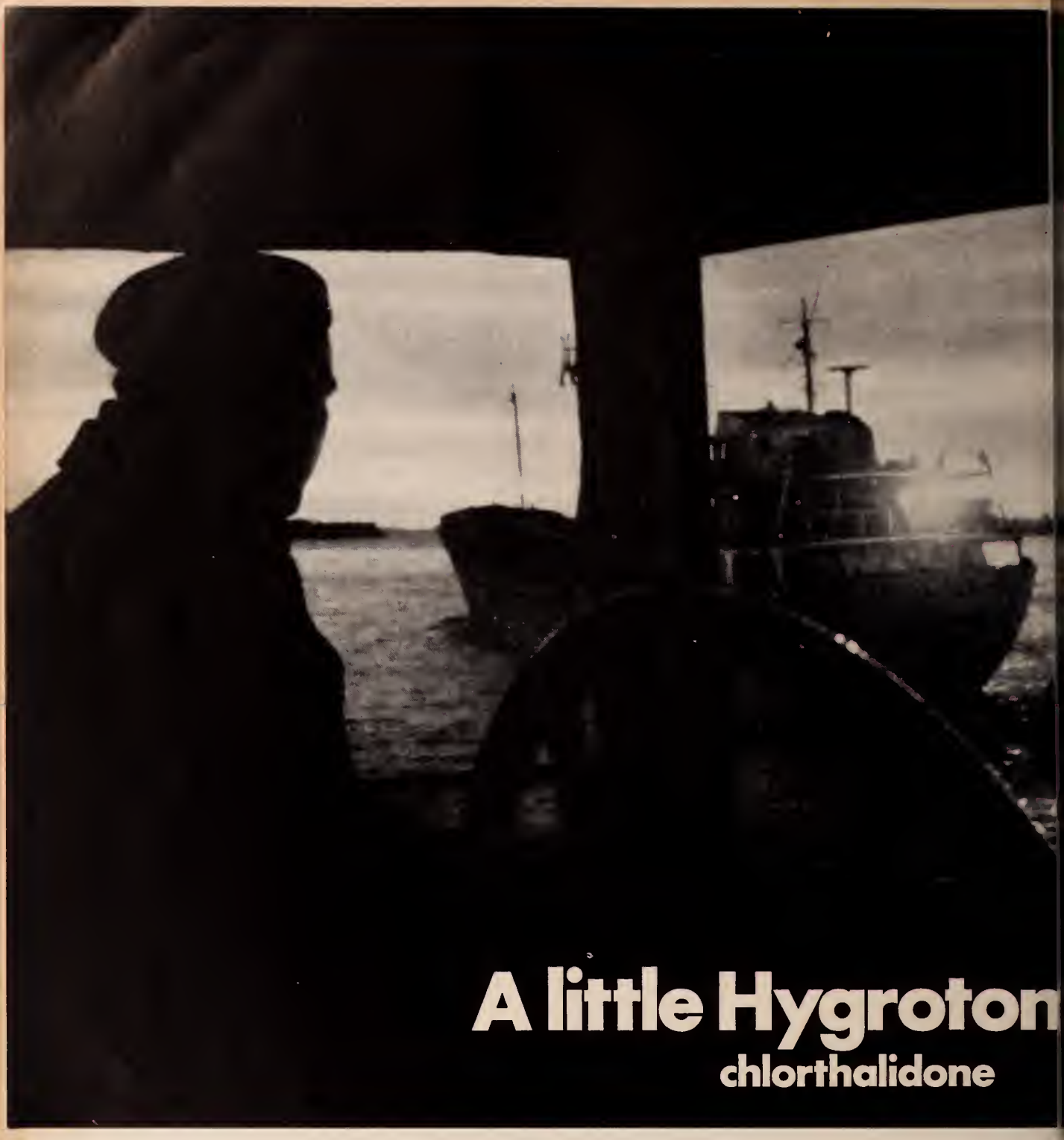
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172 Halsted Street
East Orange, New Jersey 07019

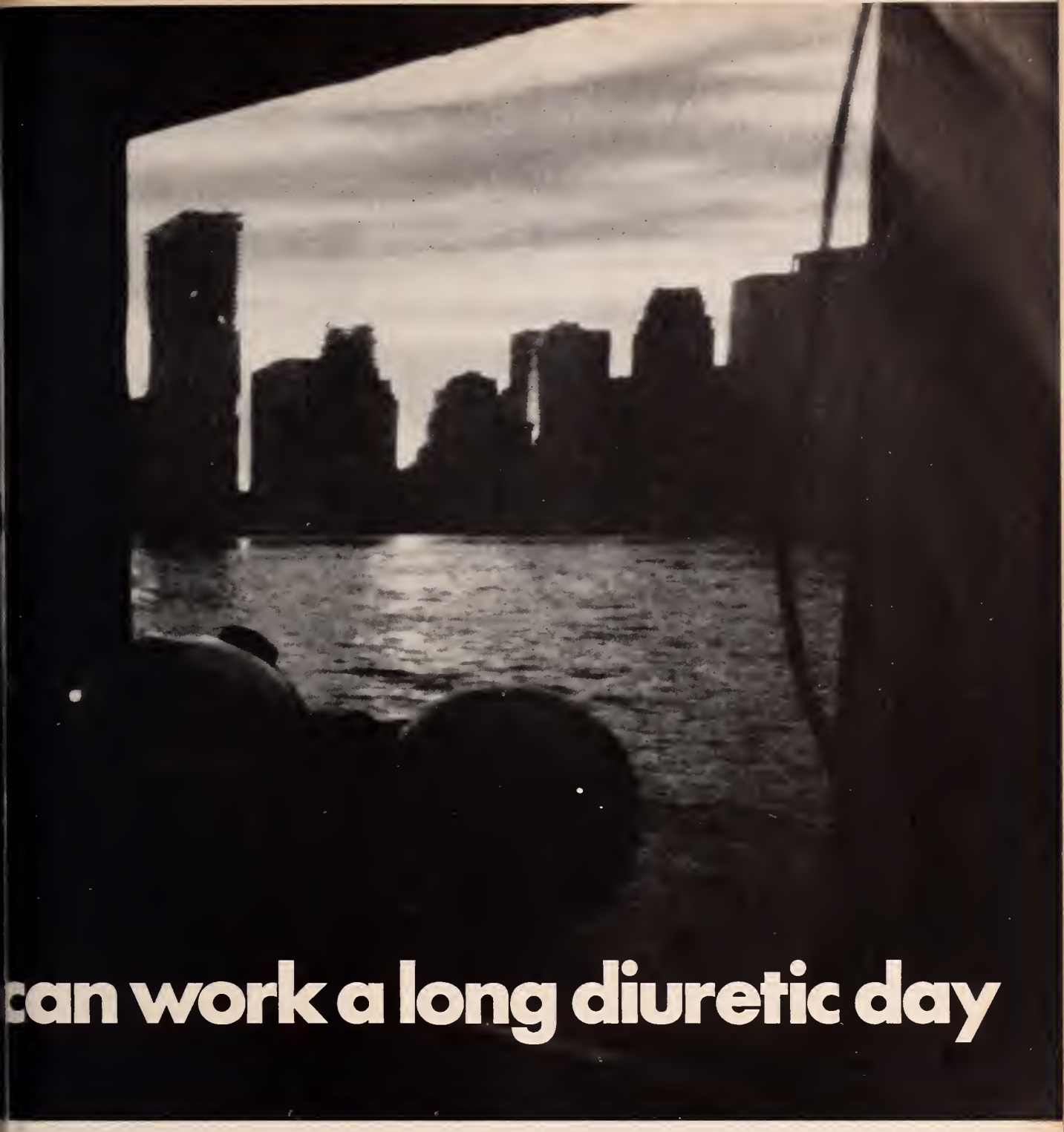
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A little Hygroton
chlorthalidone



can work a long diuretic day

ll the way from one daily tablet to the next
o help control edema and hypertension

s prolonged action usually provides smooth, sustained diuretic
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nd economy.

ygroton, chlorthalidone, can cause side effects. And it's contra-
ndicated in hypersensitivity to the drug and severe renal and
epatic diseases.

heck the prescribing information. It's summarized on the next page.

Geigy



A little Hygroton® can work a long diuretic day

chlorthalidone

Indications: Hypertension and many types of edema involving retention of salt and water.

Contraindications: Hypersensitivity and most cases of severe renal or hepatic diseases.

Warning: With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small-bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has been required frequently and deaths have occurred. Discontinue enteric-coated potassium supplements immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur.

Use with caution in pregnant women and nursing mothers since the drug may cross the placental barrier and appear in cord blood and since thiazides may appear in breast milk. The drug may result in fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult. When used in women of childbearing age, balance benefits of drug against possible hazards to fetus.

Precautions: Antihypertensive therapy with this drug should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents, other potent antihypertensive drugs or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. Because of the possibility of progression of renal damage, periodic determination of the BUN is indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated.

Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, the drug should be discontinued and potassium supplements given, provided the patient does not have marked oliguria.

Take special care in cirrhosis or severe ischemic heart disease and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended.

Adverse Reactions: Nausea, gastric irritation, vomiting, anorexia, constipation and cramping, dizziness, weakness, restlessness, hyperglycemia, glycosuria, hyperuricemia, headache, muscle cramps, orthostatic hypotension, which may be potentiated when chlorthalidone is combined with barbiturates, narcotics or alcohol, aplastic anemia, leukopenia, thrombocytopenia, agranulocytosis, impotence, dysuria, transient myopia, skin rashes, urticaria, purpura, necrotizing angiitis, acute gout, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Other reactions reported with this class of compounds include: jaundice, xanthopsia, paresthesia, and photosensitization.

Average Dosage: 50 or 100 mg. with breakfast daily or 100 mg. every other day.

Availability: White, single-scored tablets of 100 mg. and aqua tablets of 50 mg., in bottles of 100 and 1000.

(B)46-230-E

For full details, please see the complete prescribing information.

Geigy Pharmaceuticals
Division of
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Ardsley, New York 10502

HY 6074

this ulcer did not heal...until its surface was cleared of dead tissue and debris



FIRST APPLICATION
ELASE Ointment is applied to a deep ulceration of a finger.

EIGHTEEN DAYS LATER
Healing has progressed rapidly without interruption or interference from any accumulated purulence or necrotic tissue. Greatly reduced size of lesion and minimal scar tissue indicate quality and vigor of healing which is almost complete.



to aid in debridement
to facilitate healing
in chronic cutaneous ulcers...

Elase® Ointment

(fibrinolysin and desoxyribonuclease, combined, [bovine] ointment)

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By helping to remove dead tissue and debris from the ulcer's surface, ELASE Ointment creates a better environment for the elimination of infection, for healthy granulation...*for healing.* Its lytic enzymes effectively break down DNA in dead leukocytes and other debris...the fibrin in blood clots, serum, and purulent exudates...and the denatured proteins in necrotic tissue. Protein elements of *living* tissue are relatively unaffected. ELASE Ointment is indicated in stasis ulcers and in other infected or inflamed ulcers caused by circulatory disturbances. In cases requiring skin grafting, it is used preoperatively for debridement. For ambulatory patients debridement with ELASE Ointment is a convenient therapy and a regimen likely to be followed. *Precautions:* Observe usual precautions against allergic reactions, particularly in persons with a history of sensitivity to materials of bovine origin or to mercury compounds. *Adverse Reactions:* Side effects attributable to the enzymes have not been a problem at the dose and for the indications recommended. *Discussion:* Successful use of enzymatic debridement depends on several factors: (1) dense, dry eschar, if present, should be removed surgically before enzymatic debridement is attempted; (2) the enzyme must be in constant contact with the substrate; (3) accumulated necrotic debris must be periodically removed; (4) the enzyme must be replenished at least once daily; and (5) secondary closure or skin grafting must be employed as soon as possible after optimal debridement has been attained. It is further essential that wound-dressing techniques be performed carefully under aseptic conditions and that appropriate systemically acting antibiotics be administered concomitantly if, in the opinion of the physician, they are indicated. *Available:* ELASE Ointment is supplied in 30-Gm. tubes containing 30 units (Loomis) of fibrinolysin and 20,000 units of desoxyribonuclease with 0.12 mg. thimerosal (mercury derivative); and in 10-Gm. tubes containing 10 units of fibrinolysin and 6,666 units of desoxyribonuclease with 0.04 mg. thimerosal. ELASE Ointment has a special base of liquid petrolatum and polyethylene; contains sodium chloride and sucrose used during manufacture; is stable at room temperature through the expiration date stated on the package.

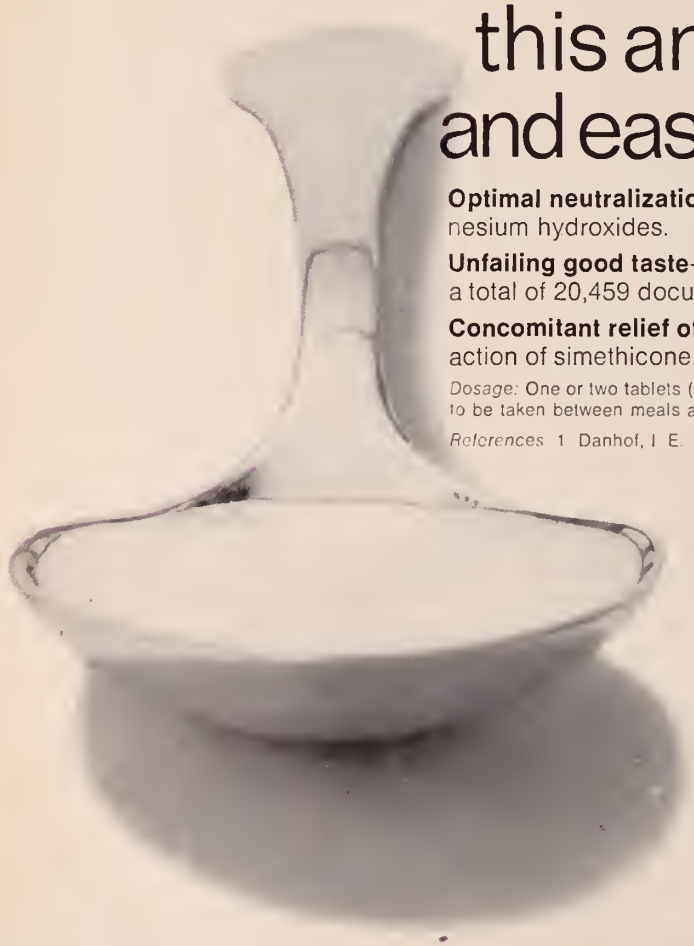
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References 1. Danhof, I. E. Report on file 2. Hoon, J. R.: Arch. Surg. 93:467 (Sept.) 1966.

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Precautions: Drowsiness, anorexia, slight gastric distress can occur. In excessive drowsiness, consider longer dosage intervals. Persons on full dosage should not operate vehicles. Nonsusceptible organisms may overgrow; treat superinfection appropriately. Treat beta-hemolytic streptococcal infections at least 10 days to help prevent rheumatic fever or acute glomerulonephritis. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

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Warn patients of possible reduced alcohol tolerance, with resultant slowing of reaction time and impairment of judgment and coordination.

Reduce dose if drowsiness, ataxia or visual disturbance occurs; if persistent, patients should not operate vehicles or dangerous machinery.

Side Effects include drowsiness, usually transient; if persistent and associated with ataxia, usually responds to dose reduction; occasionally concomitant CNS stimulants (amphetamine, mephentermine sulfate) are desirable. Allergic or idiosyncratic reactions are rare, but such reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Previous history of allergy may or may not be related to incidence of reactions. Mild reactions are characterized by itchy urticarial or erythematous maculopapular rash, generalized or confined to groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. One fatal case of bullous dermatitis following intermittent use of meprobamate with prednisolone has been reported. If allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Treat symptomatically as with epinephrine, antihistamine and possibly hydrocortisone. Aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia have occurred rarely, almost always in presence of known toxic agents. A few cases of leukopenia, usually transient, have been reported on continuous administration.

Meprobamate may sometimes precipitate grand mal attacks in patients susceptible to both grand and petit mal. Extremely large doses can produce rhythmic fast activity in the cortical pattern. Impairment of accommodation and visual acuity has been reported rarely. After excessive dosage for weeks or months, withdraw gradually (1 or 2 weeks) to avoid recurrence of pretreatment symptoms (insomnia, severe anxiety, anorexia). Abrupt discontinuance of excessive doses has sometimes resulted in vomiting, ataxia, tremors, muscle twitching and epileptiform seizures. Prescribe very cautiously and in small amounts for patients with suicidal tendencies. Suicidal attempts have resulted in coma, shock, vasomotor and respiratory collapse and anuria. Excessive doses have resulted in prompt sleep; reduction of blood pressure, pulse and respiratory rates to basal levels; and occasionally hyperventilation. Treat with immediate gastric lavage and appropriate symptomatic therapy. (CNS stimulants and pressor amines as indicated.) Doses above 2400 mg./day are not recommended.

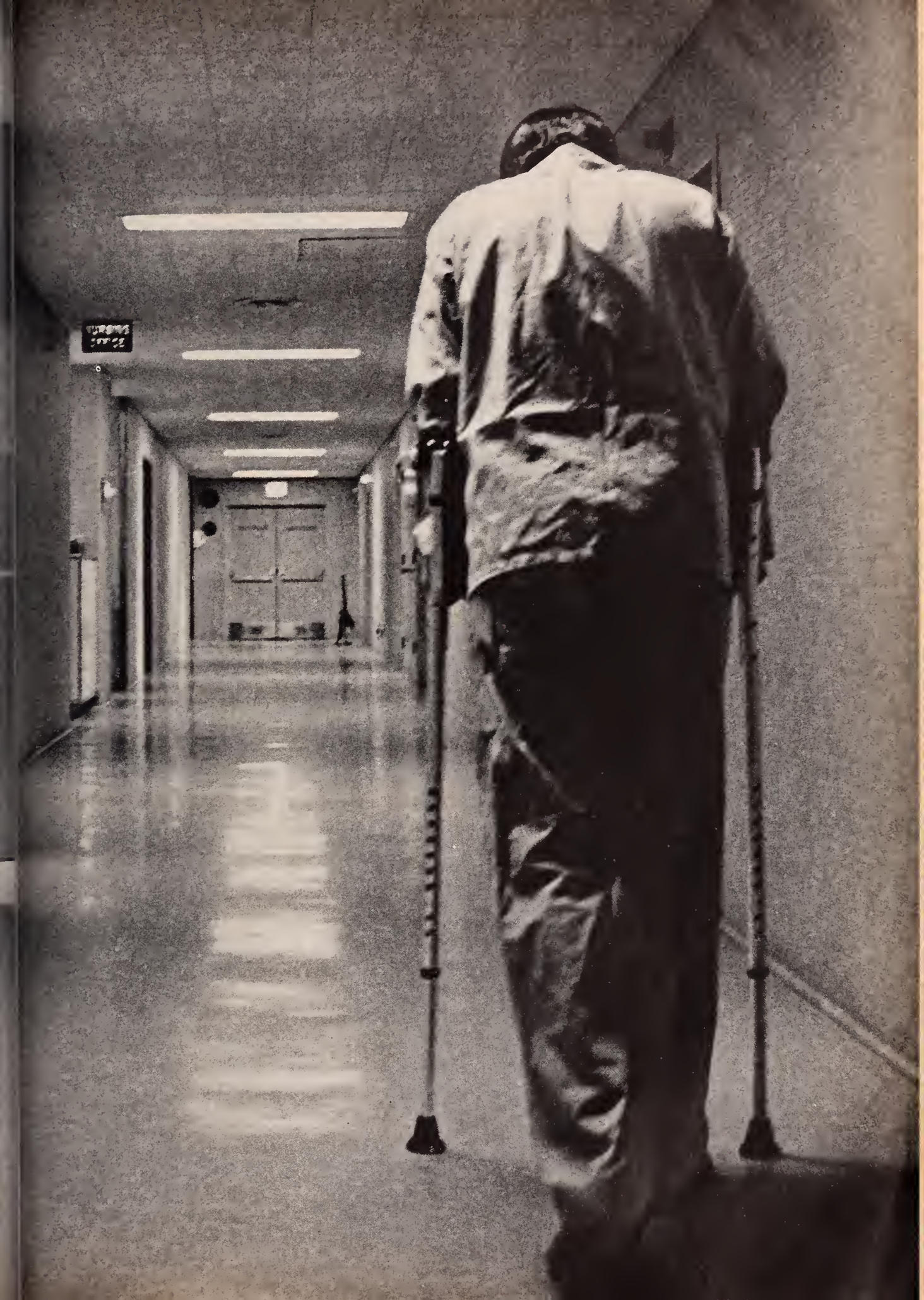
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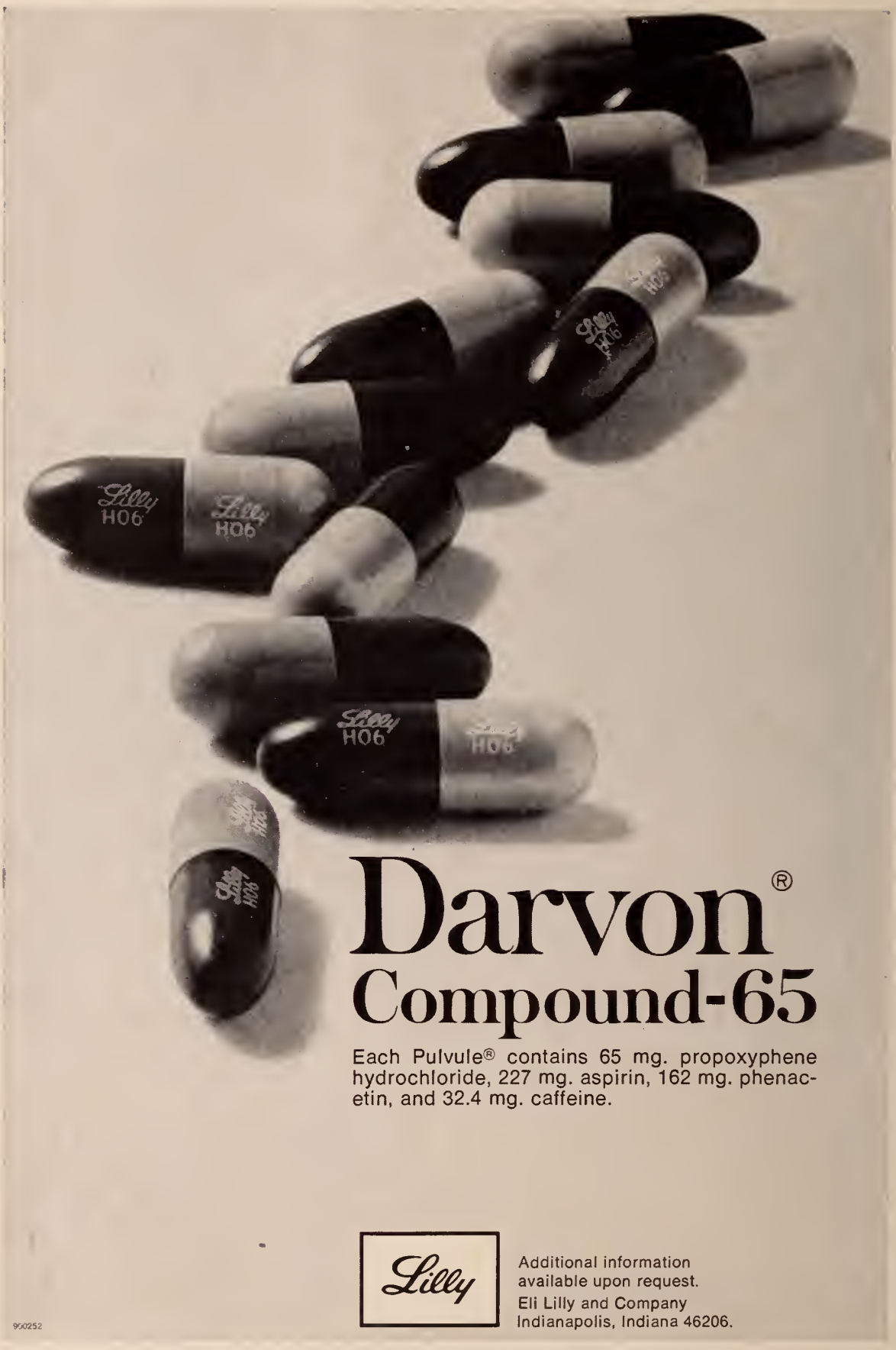
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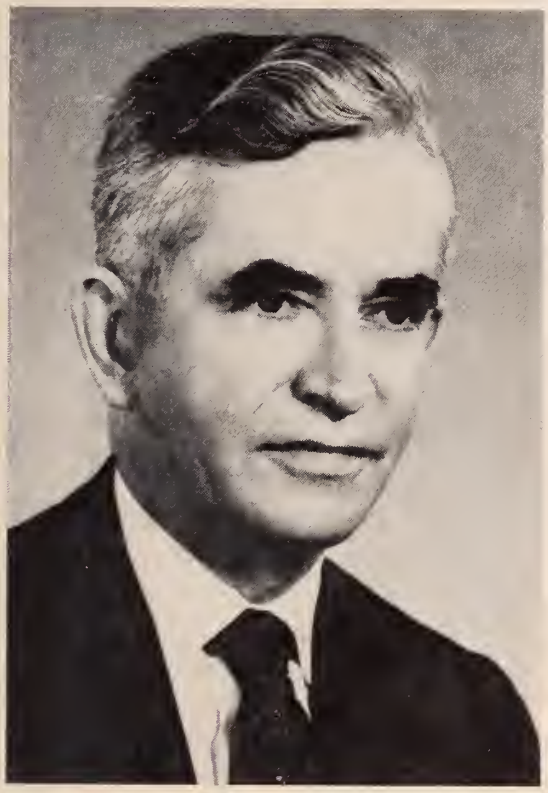
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EDITORIALS

And Here Is Nick Bertha



It is traditionally said that if you want a job done soon and done properly give it to a busy man. That must have motivated many organizational officials to turn jobs over to Nick Bertha.

A native of Morris County, New Jersey, Nicholas Aladar Bertha acquired his B.S. at New York University and his M.D. at Bellevue. He was soon attracted to surgery and developed recognized skill, becoming a Fellow of the American College of Surgeons, and eventually president of the distinguished Society of Surgeons of New Jersey. He is senior attending surgeon at the Dover General Hospital and at St. Clare's Hospital in Denville.

We are all urged to devote time and attention to civic and organizational activities, but most of us seem to have little inclination toward such activities and give little time to them. Nick Bertha, however, can't escape. It was not enough for him to be a senior attending surgeon at these two hospitals; he wound up being president of the medical staff too. He became a trustee of The Medical Society of New Jersey, which one would think would be honor enough. But then his colleagues made him chairman of that Board. When the New Jersey Chapter of the American College of Surgeons picked an executive council, Nicholas A. Bertha was on *that* council, of course. He was active in his Morris County Medical Society, and—you've guessed it—they made him president of that organization too. Like all good surgeons, he was interested in the problem of cancer and challenged by its awesome possibilities. He is very active in the state committee for the American Cancer Society. He has, in a word, become one of New Jersey medicine's first citizens, and he now starts his term as President of The Medical Society of New Jersey.

It sounds as if we are in good hands!

No More Scruples

We went behind the screen in a pharmacy the other day. The apothecary handed us a little weight with a stylized "℥" on it. "Recognize this?" We confessed that we didn't, though the symbol looked vaguely familiar.

"Ah", he said, "this is a scruple. Perhaps this is the last scruple in town. No one ever prescribes medication in scruple doses any more."

A memory slowly returned. "Twenty grains equal one scruple. Three scruples equal one drachm. Eight drachms equal one ounce."

The word itself stems from the Latin *scrupulus* meaning "small stone" reminiscent of an earlier "scrupa" for stone. Indeed, "scrotum" comes from the same word — stone. A small pointed stone was used to chip other stones, as diamonds are used to cut diamonds. So *scrupulus* became the stony little shredder.

The little pointed stone became the prick of conscience (scruple in the modern sense). To the Romans it was a way of expressing the smallest weight they could use—the little piece of stone—*scrupulus*. Precious stones were weighed in units of 24—each being a carat. So other items were weighed in units of 24 (a 24th of an ounce), each unit being then a scruple. The scruple then was standardized as the 24th of an ounce—and when the drachm was developed as an eighth of an ounce, a drachm was equated to three scruples. Not until centuries later, could people handle a smaller unit—the grain.

With the dawn of the Middle Ages, man began to wrestle with his conscience. Sometimes he would be hesitant in his anxiety to determine what was right and what was wrong. The smallest matter might provoke a doubt. A less compulsive man might laugh and say that this was too trifling a matter over which to hesitate. But the more conscientious person would not risk his ticket to eternal life by falling down on even the most trivial matter. Hence the world "scruple"—symbol of the smallest weight—became the word to describe the trifle that caused the troubled man to hesitate. The word was also used in another sense. The ancients balanced their crude scales on a small sharp-pointed stone which served as pivot So this small stone (*scrupulus*) became a term for the axis on which delicate matters could be balanced.

Here then is the rich and romantic history of an ancient apothecary's weight. A generation or two ago the pharmacist was the heir of the alchemist; he was the artist who compounded the prescription. He did it with care, measuring every scruple, every drachm, every grain. He was precise. In both senses of the word, he had scruples.

Today's medical student knows neither the word nor its symbol. Well, we no longer need that weight. With our sterile, colorless, but efficient metric system, we can forget the drachms, and grains—aye—the scruples too—that once lent color and variety and preciseness to the ancient art of the apothecary. We do just that.

The Auxiliary's Rita MacDonald



Though she doesn't seem old enough to have done all these things, Rita MacDonald has been president, chairman, or secretary of such varied organizations as a day nursery, a girl scout group, the County Auxiliary, the Associated Guilds and the Maternity Guild at St. Elizabeth Hospital, the Homemaker Service of Central Union County, and on and on.

A native of Roselle Park, she is a graduate of New York's Pace Institute. She was the corporate secretary of a large Savings and Loan Association until Ed MacDonald took her away. Edward MacDonald (and we are allowed to mention husbands only briefly) is an Elizabeth surgeon—chief of staff and director of medical education at St. Elizabeth Hospital. Their son-in-law is Assistant Administrator at the Kessler Institute, and their daughter is a medical social worker at the Hospital Center in Orange.

So, here is the chance to meet Rita MacDonald!

ORIGINAL ARTICLES

In this ringing call for self-discipline and maintenance of ideals, our incoming President sets the challenge for all of us.

Medicine:

A Disciplined Profession*

Nicholas A. Bertha, M.D./Wharton

Today I am here to express my gratefulness to you for your generosity and graciousness in choosing me to serve as the 177th President of The Medical Society of New Jersey, and to set forth for you my concepts of the goals that together we must pursue and the ideals that we must continue to preserve and advance. I accept the honor and the duties of office with full and dedicated heart. I pledge you my best for our Society, our profession, our people, and our nation.

I can think of no time when the need for good members of the profession of medicine was greater than today, not only for the maintenance of the integrity and distinction of the profession, but also for the delivery, in increasing volume, of the quality medical care which more and more people seek and require with every passing day.

The character of medicine as a noble calling and its preservation from deterioration to the level of a soulless business enterprise, directly depend on the dominance of good men and women in its ranks.

Were I asked to specify what are the elements that constitute a good member of the profession of medicine, I should answer: "Disciplined intelligence, idealistic dedication to the betterment of the lot of one's fellowmen, ordinate dignity and self-respect, based on unbiased self-evaluation, sound habits of work, strong spiritual convictions and moral principles, a sense of justice, and a heart of compassionate understanding." A person possessing those elements would be an asset to any undertaking with which he would identify himself, but he is necessary to the profession of medicine in order that it may go on serving mankind in the pattern that has made it great, and that it may fulfill the high expectations with which people everywhere continue to look to it.

This is not a time in the life of the world when the attributes that I have been enumerating as necessary in the members of the medical profession flourish and manifest themselves in the patterns of popular contemporary living. The individual who as a member of the profession of medicine exemplifies these attributes cannot expect to be anything but exceptional in relation to the general run of people. Though others are self-indulgent and unaspiring, he must not be. Though others abandon considerations of human dignity and principles of moral rectitude, he may not. Though others demand of themselves less than their best, he must not. For the duty of the doctor of medicine is to improve the health and the life of his fellowmen, by his knowledge and skills as a practitioner, and by his actions and example as a member of society.

* Delivered to the General Session, The Medical Society of New Jersey, May 18, 1969, Atlantic City.

For all these reasons we need good members of the medical profession as never before. More than the bodily health of people is at stake in our country today. Our worth and dignity as human persons and our health and life as a people and as a nation are likewise in balance. The need for constructive help is dire.

We as a profession have a duty to do what we can collectively and individually to meet that need. It is one of my purposes to encourage all our members — and especially to exhort our younger members — to unite vigorously in the effort to do what we can.

Let me offer some specifics for a *modus operandi*. I shall limit myself to suggestions for crystallizing and maximizing our efforts to meet the growing challenge for increased and expanded delivery of quality medical care.

First, as The Medical Society of New Jersey has repeatedly emphasized, in the education and training of young men and women for the profession of medicine, in the choice and content of all courses given, primary emphasis must be placed on patient care. While a selected minority may properly be encouraged to dedicate themselves to research — and admittedly research is basic to the advancement of both the science and art of medicine — the great majority of medical students must be encouraged and channeled into clinical medicine. The triumphs of medical research are hollow, if their benefits are not made readily available to people in need of them.

For this reason I regard the field of general practice as basic and indispensable for the doctor of medicine who is to bring the newest and best that medicine has to offer to the patients whom he treats. The medical manpower shortage is nowhere more marked than in the ranks of general practitioners. Nevertheless, I cannot see how we of the medical profession can seriously consider permitting so-called paramedical personnel to substitute for physicians in the care of patients, no matter how glibly we are assured that all final decisions will be made by physicians acting upon the reports of their field assistants. It is my personal conviction that the best interests of the public would be ideally served if all young doctors of medicine were required to serve a stipulated minimum of years in general practice before being permitted to decide upon or embrace a specialty. Possibly influence could be brought to bear upon medical school and governmental authorities to establish one year rotating internships, followed by a two or three year term as a general practitioner in a chosen community as prerequisite for entry upon specialty training.

Secondly, I recommend that we work together to achieve among all our members — particularly among those newly entering practice — the realization, or re-recognition, of the fact that the fundamental purpose underlying the education and training of a physician is the advantage of his patients and not his personal advantage. Even were a medical student to meet all the expenses of his own tuition, his payments would satisfy only a fraction of the costs involved. Other people's money — supplied either through the philanthropy of individuals or from public funds — is necessary to make possible the education of every doctor of medicine. That money is made available not as a discriminating favor to him but to prepare him as a doctor of medicine to serve the general good in proportion to his abilities and advantages. All members of the health professions — and indeed of other professions, such as the ministry and teaching — are educated to the end that they may serve others according to their abilities. To reason otherwise, although increasingly popular in the philosophy of our times, is to reason fallaciously.

Thirdly, I think we should work together to make all our members — especially our younger members — involve themselves in the decisions and activities of our Medical Society and our profession, and in the attempts to deal with the changing conditions and challenges of our times. We are part of, and responsible for, our profession, our social circumstances, our contemporary life, our inter-relationships as a people, and our status as a nation among the nations of the world. Every one of us — and I speak now of all American citizens in

all walks of life — should starkly realize that all contemporary problems are our responsibility as individuals to strive to solve. That is the wholesome spirit of a healthy democracy. He who shirks his personal responsibility in any area of vexed concern is recreant to himself as a man and as a member of civil society. Fundamental and undesirable changes are frequently brought about by the aggressive industry of the few abetted by the inexcusable and spineless apathy of the many.

In this consciousness, as I enter upon my work as President of The Medical Society of New Jersey, I address myself to you and to all our members. I shall strive to set the example and the pace. I shall gladly do your bidding, but I cannot do your work. We must all work together, counsel together, serve together, and succeed or fail together.

Let us be distinguished by vigor of mind and valor of spirit. Let us be strong, vigilant, active, and brave. The ends we serve could scarcely be more inspiriting — the well-being of our fellowmen, the exaltation of our profession, the fulfillment of our personal destinies, and the enduring good of our country.

83 South Main Street

Ambulance Services Criticized

The National Research Council charged that most ambulances in the U.S. are not "providing emergency care to the critically injured." It cited untrained attendants and a lack of equipment and supplies. The Council said that: "hearses and station wagons, commonly used as emergency vehicles, do not carry the necessary equipment or provide the space for such equipment for the carrying out of modern resuscitative procedures either at the scene of an accident or during transportation." It urged that "action must be taken to develop and enforce nationwide standards for ambulance service," because accidental injuries are the leading cause of death during the first half of a person's life span.

"Only ten states have statutes prescribing the equipment to be carried by an ambulance, and the federal guidelines for motor safety do not cover the special features necessary to safe transport of the critically ill or injured," the council reported.

The National Research Council is a subsidiary of the National Academy of Sciences, an organization created by a congressional charter in 1863.

Educational Tape Recordings For M.D.s

Audio News Journal is a once-a-month, 65-minute tape recording highlighting current medical events throughout the world. Initial charter subscribers received their first tape in January, 1969. This service is a practical means of permitting you to keep pace with medical developments by playing all or segments of a recording during "idle" or "unproductive" moments. The recordings are playable at home, in the office, or in the car. This service, however, is not intended as a medium to provide verbal reporting of scientific papers or condensation of published medical news. Instead, the focus is on-the-scene coverage of major medical meetings, new developments in the health field and interviews with health professionals and public figures on political, social, and economic aspects of medicine.

Subscribers may choose from three types of tapes: eight-track stereo, cassette, or reel-to-reel. Annual subscription for the informational service is $72 for physicians in the USA. Send your subscription order to the AMA Circulation and Records Department, 535 North Dearborn Street, Chicago, Illinois 60610.

Drainage is still the definitive therapy for subphrenic abscess. Antibiotics should be administered on the basis of the organism cultured.

The Subphrenic Abscess: A Clinical Review*

Arthur E. DePalma, M.D./ Portland, Oregon

Subphrenic abscesses have been diagnosed for over 100 years, but there continues to be controversy regarding their anatomic structure. Because of the proximity to the pleural cavity as well as to the liver, the subphrenic abscess presents a thoracoabdominal clinical complex as suggested by Carter.[1] Often, however, there are practically no clinical findings to suggest an abscess in the subphrenic region. About 10 to 15 per cent of patients with this disease are diagnosed only at postmortem examination.[2] Barnard's aphorism[3] — "signs of pus somewhere, signs of pus nowhere else, signs of pus there" is often as applicable today as it was in 1908.

The subphrenic space is bounded above by the diaphragm, below by the transverse colon and mesocolon, and divided into suprahepatic spaces by the liver. Strictly speaking, however, a subhepatic abscess is not in contact with the diaphragm and so should not be considered subphrenic. The literature prior to 1958 divided the subphrenic space into six regions:

1. Right anterior suprahepatic
2. Right posterior suprahepatic
3. Right subhepatic
4. Left suprahepatic
5. Left anterior infrahepatic
6. Left posterior infrahepatic

Boyd[4] pointed out that because the triangular ligament suspends the liver by extending from the dorsum of the diaphragm to the posterior margin of each hepatic lobe, there are really only two spaces on each side — the right suprahepatic or subphenic space, the right subhepatic space; the left subphrenic-subhepatic space and a space which is the same as the lesser peritoneal sac.

The literature was reviewed with regard to etiology, distribution, symptomatology, diagnosis, and prognosis of subphrenic abscesses and compared with the records of 23 cases of subphrenic abscess at the Presbyterian University Hospital, Pittsburgh, from 1959 through 1965. Twenty of those were confirmed at surgery or autopsy. Of the 23 cases reviewed, 15 were males. Average age was 49 years.

Etiology

The usual source of an abscess is intra-abdominal disease. Moore[5] found 30 per cent of the abscesses secondary to stomach and duodenal disease and 30 per cent secondary to biliary disease (although he had eliminated the posterior-superior and subhepatic spaces on the right in his report of cases.)

Berens[6] (who included abscesses in any of the six classical spaces in his study) also lists stomach and duodenal causes as 34 per cent with another 18 per cent following surgery of the stomach and 16 per cent following rupture of a duodenal or gastric ulcer. In Berens' series biliary tract surgery accounts for about 20 per cent of subphrenic abscesses and rup-

* From the Presbyterian University Hospital in Pittsburgh, and from the New Jersey State Department of Health in Trenton, where Dr. DePalma was Principal Investigator, Pesticide Project. As of July 1 he will be associated with the University of Oregon Hospitals in Portland, Oregon.

ture of the gall bladder or biliary tract accounts for about 7 per cent. Only one of about a dozen series included splenectomy as a major cause of subphrenic abscess.[7]

In the 23 cases reviewed, splenectomy accounted for five in which splenorenal shunts were done in two cases. Cholecystectomy was followed by an abscess in seven cases, in two of which choledochostomy was also done. A subdiaphragmatic abscess followed gastrectomy in only one case. Fifteen of the 23 cases of abscess occurred following surgery. The breakdown of etiologic factors in the present series is seen in Table I.

TABLE I

Biliary Tract — 8 or 34%
- postcholecystectomy — 5 or 21%
- postcholecystectomy plus choledochostomy — 2 or 8%
- gangrenous cholecystitis — 1 or 4%

Spleen — 5 or 21%
- splenectomy alone — 3 or 13%
- splenectomy with splenorenal shunt — 2 or 8%

Abdominal Trauma — 3 or 13%
- Acute appendicitis with peritonitis — 8%
- Colectomy — 1 or 4%
- Hysterectomy — 1 or 4%
- Gastrectomy — 1 or 4%
- Perforated ileum — 1 or 4%
- Leukemia — 1 or 4%

This list can be compared with Table II from the review by Moore[5] which lists etiologies found by other authors.

Signs and Symptoms

The present series is divided into four categories according to location of the abscess. Table III lists signs and symptoms seen in patients with a right subphrenic abscess.

Abdominal pain was usually present in the right *upper* quadrant although one patient (whose abscess was preceded by appendiceal rupture and peritonitis) had *lower* abdominal pain. Two patients with a cough had purulent sputum, one of which developed a lower lobe abscess with eventration of the diaphragm and herniation of a lobe of the liver secondary to trauma suffered in a car accident. The abscess was drained, the defect was repaired and the patient recovered. Seventy-one per cent had chest pain or some abnormal pulmonary sign or symptom. Table IV lists the radiologic findings of patients with a right subphrenic abscess.

TABLE II

Author	No. Cases	Appendix %	Stomach Duodenum %	Biliary Disease %	Other Diseases* %
Whipple, 1926	1000	21	30	16	33
Oschner & Graves, 1933	3372	30	29	12	28
Gogol, 1938	50	26	36	12	26
Faxon, 1940	175	31	27	21	21
Shea & Holden, 1948	40	25	42.5	15	17.5
Cameron, 1952	49	5	41	15	39
Berens, 1953	154	15	34	27	34
Harley, 1955	188	19	31	21	46
Wooler, 1956	50	16	38	10	36
Wetterfors, 1959	101	10	38	33	19
Moore, 1963	10	10	30	30	30

* Gynecologic, Colonic, Trauma, Boils, Actinomycosis, Ulcerative Colitis, Hydatids, Liver Abscess, Unknown.

TABLE III

Right Subphrenic Abscess — 7 patients, proved at surgery or autopsy

Signs and Symptoms	*No.*	%
1. Abdominal pain	5	71
2. Drainage from original operative site	1	14
3. Chest and shoulder pain	1	14
4. Decreased breath sounds and dullness-right base	3	43
5. Cough	3	43
6. Chest pain or abnormal pulmonary sign or sympton	5	71

TABLE IV

X ray Findings	*No.*	*%*
Subphrenic gas pattern or fluid level	5	71
Pleural effusion	4	57
Elevated diaphragm	4	57
Normal	0	0

Tables IX and X list the signs, symptoms and x-ray findings in three patients who did *not* have their diagnosis confirmed at surgery or postmortem.

TABLE V

Left Subphrenic Abscess — 7 patients, proved at surgery or autopsy

Signs and Symptoms	*No.*	*%*
1. Abdominal pain	2	28
2. Drainage from original operative site	5	71
3. Rales	4	57
4. Chest and/or shoulder pain	3	43
5. Decreased breath sounds and dullness-left base	2	28
6. Chest pain or abnormal pulmonary sign or symptom	5	71

Table V lists signs and symptoms in patients with a left subphrenic abscess. Five were post splenectomy. One had a perforated illeum and one patient with leukemia was found to have an unsuspected abscess at autopsy. Seventy-one per cent had chest pain or some abnormal pulmonary sign or symptom.

TABLE VI

X ray Findings	*No.*	*%*
Subphrenic free gas pattern or fluid level	2	28
Pleural effusion	3	43
Elevated diaphragm	2	28
Normal	2	28

Table VI lists x-ray findings present in the patients with a left sided abscess. No chest x-ray was taken on one patient.

TABLE VII

Subhepatic Abscess — 6 patients, proved at surgery or autopsy

Signs and Symptoms	*No.*	*%*
1. Abdominal pain	4	67
2. Drainage from original operative site	1	17
3. Palpable tender RUQ mass	3	50
4. Decreased breath sounds and dullness	1	17

TABLE VIII

X ray Findings	*No.*	*%*
Subphrenic free gas pattern or fluid level	1	17
Pleural effusion	2	33
Elevated diaphragm	3	50
Normal	3	50

Tables VII and VIII list the signs, symptoms and x-ray findings in those patients with a subhepatic abscess.

TABLE IX

Site of Abscess Unknown — 3 patients, no surgery or autopsy performed

Signs and Symptoms	*No.*	*%*
1. Abdominal pain	1	33
2. Chest pain	2	67
3. Decreased breath sounds and dullness	2	67

TABLE X

X ray Findings	*No.*	*%*
Pleural effusion	1	33
Elevated diaphragm	2	67
Pneumonia	1	33

TABLE XI

Comparative Summary of Clinical and X ray Findings

	This series	*Berens*[6]
Pain	56.5%	73.4%
Abdominal pain	50	—
Chest and/or shoulder pain	30	—
Rales, decreased breath sounds, dullness	56.5	51.9
Cough	17	14.3
Increased drainage—operative site	30	31.5
Palpable abdominal mass	13	19.5

	This Series	*Berens*[6]	*Carter*[1]
Abnormal chest film	77%	—	—
Normal chest film	23	—	11%
Pleural effusion	46	44.3%	—
Air or fluid level subphrenic space	36	24.8	37.5
Elevated diaphragm	46	60.4	—
Lung abscess	4.5	—	—
Pneumonia	4.5	30	—

Table XI compares the clinical findings of this review with those of several other investigators.

Except for the higher incidence of pain and parenchymal lung changes, Berens' clinical findings[6] correlate closely with this review. Carter found a lesser incidence of normal chest x-rays in his series.[1] The leukocyte count was over 12,000 in 20 of 22 patients. It ranged from 5200 to 41,000 with an average of 19,000. The mean PMN and band count was 80 per cent ranging from 65 to 97 per cent.

Complications; Prognosis

Complications developed in 8 patients (36 per cent). Three developed a recurrence of the abscess necessitating redrainage. (One patient with ulcerative colitis also developed an abdominal wall abscess.) One patient had pseudomonas cultured from her blood on the day of her death from septicemic shock. Another was found to have Proteus bacteremia at autopsy although blood cultures during

life were negative. Four developed a small bowel fistula, a pulmonary embolus, a wound infection and a bronchopleural fistula respectively.

A multitude of other diseases were present in this series including cirrhosis and hypersplenism. One each had leukemia, diabetes, sclerosing cholangitis, and malignant hypertension with uremia. There seemed to be no correlation between the pathologic state of the patient and the complications. Wetterfors[8] in a series of 101 cases found an incidence of 43 per cent complications. He reported 6 per cent peritonitis, 3 per cent colon perforation, 2 per cent pyopneumothorax, and 5 per cent pericarditis. Although three patients in our series had peritonitis, this antedated or was concomitant with the subphrenic abscess. We had six deaths in this series. Three followed perforation of a viscus. One was a leukemic patient with an unsuspected left subphrenic abscess found at autopsy, along with abscesses in multiple other sites which grew out Nocardia, and one patient died following major trauma.

Bacteriology

E. coli, coagulase positive Staphlococcus, or Streptococcus are the predominant organisms found in conjunction with a subprenic abscess.[6,12] In this series, these three organisms were also the most prominent. Of 19 abscesses cultured 11 grew out only one organism. Seven were mixed and one was sterile. Klebsiella, Proteus, Bacteroides, Pseudomonas, and Aerobacter were some of the other organisms occasionally cultured.

Treatment

Fifteen patients had an incision and drainage; of these four lated died. Five were treated with antibiotics only, three did well and two died. The abscess drained spontaneously through the operative site in three patients with disappearance of signs and symptoms.

Their average time between onset and drainage in those who had the abscess drained following a specific episode (except for three patients) was 18 days. One man who had been in a serious auto accident, received multiple lacerations of the liver. His abscess was drained a year after his initial trauma and laparotomy. He had been well until a few weeks before admission at which time he developed a productive cough, fever, chills, sweating, and chest pain. Another suffered left sided pleuritic pain two months after a splenectomy. His chest film showed free air under the left hemidiaphragm. A third had a difficult cholecystectomy and common duct exploration at another hospital. Two months later she had a palpable mass in the right upper quadrant, weakness and nausea. Including these three patients, average time between onset and drainage was 51 days. Dineen[9] had an average of 32 days ranging from 4 to 240 days in his series.

Discussion

Most subphrenic abscesses arise from intra-abdominal disease or surgery. The present series differs from others presented in that it has a much smaller incidence of abscesses following gastro-intestinal surgery or rupture of an upper gastro-intestinal viscus; a much greater incidence following splenectomy (except for Roger's study[7]), and a much smaller incidence of abscesses following appendicitis and appendiceal rupture.[5] Except for stomach and duodenal diseases, this series is in agreement with Bondi's statement:[3]

> "In the past, appendiceal perforation was considered one of the most common causes of infection of the subphrenic space. At present it seems that perforative lesions of the stomach and duodenum, infective lesions of the biliary tract and traumatic operations in the pancreas and spleen play a more important pathogenic role."

Left sided subphrenic abscesses (or subhepatic abscesses involving the lesser sac) tend to result from operations on the left side of the abdomen involving the spleen or tail of the pancreas. Trauma and lower abdominal surgery may result in an abscess on either side, and surgery on the biliary tract, stomach, and, duodenum can cause a right subphrenic abscess. Appendiceal rupture, appendectomy, and biliary tract surgery are also frequent causes of a subhepatic abscess.

Harley[10] believes that localization of infection in the subphrenic spaces is aided by mechanical factors, e.g., intestinal peristalsis, moving

the fluid to a dependent area when the patient is reclining, and the increased negative pressure in the space on deep inspiration. However Lemon[11] and Hahn[12] have demonstrated that particulate graphite and tagged red cells are carried in the lymph stream to the subdiaphragmatic space, which may explain an abscess in this region.

Fever, malaise, and tachycardia were present in most patients. The leukocyte count was found to be elevated in all but three patients. The rise usually occurred rather suddenly and a week or two postoperatively which indicated that an infectious process was occurring. Shea[13] noted a similar degree of leukocytosis, but Gerwig[14] and Moore[5] found that the white count was usually within normal limits.

Those patients with left sided abscesses had a markedly higher incidence of draining operative sites (71 compared with 14 per cent). Possibly this is because as Moore[5] states, the pus is allowed to "push down" rather than be retained under the diaphragm. In contrast to his feeling that the left sided abscess is really abdominal (because of its abdominal presentation and treatment) and should rarely produce marked radiologic signs, in our series 43 per cent of the patients had a pleural effusion or other x-ray signs and 71 per cent had a "thoracoabdominal clinical complex." Patients with a right sided abscess generally had a higher incidence of abdominal pain and tenderness than those with left sided abscesses; but patients with left sided abscesses had a much higher incidence of drainage from the original operative site, probably accounting for the absence of pain in many cases as the abscess had an outlet. Those with subhepatic abscesses had a high incidence of abdominal pain and tenderness. Half had a palpable mass which was a finding unique to this location. Only one of six was noted to have dullness at the lung base, the only thoracic sign or symptom in the group. The paucity of a clinical thoracic picture is in agreement with Moore's statement[5] that the subhepatic abscess is abdominal, nor truly subphrenic and the pus is not in contact with the diaphragm.

The chest x-ray was suggestive or diagnostic in 77 per cent of the patients in the series. X-rays were slightly more helpful in diagnosing right sided subphrenic abscesses, although only two patients with a left sided abscess had negative x-rays. The presence of air or a fluid level beneath the diaphragm on the right is more helpful, since the liver is beneath the gas shadow, whereas it is easier to confuse gas in a viscus with free air on the left. Both Carter[1] and Gerwig[14] agree that an air pocket or air fluid level in the subphrenic area is the most important diagnostic or even pathognomonic finding in diagnosing a subphrenic abscess. Carter[1] found this in 37 per cent of his cases. Brown[15] recently published the results of a new diagnostic method using radioisotopes to outline the space between the lung and the liver. They have diagnosed three abscesses in their trial study on ten patients and have found no false positives or negatives.

Boyd[16] explains the thoracic complications of a subphrenic abscess by postulation that the purulent exudate finds the soft diaphragm and lung less of a barrier than the rigid liver and posterior parietal structures. Supradiaphragmatic involvement can also be explained by lymphatic spread above the diaphragm causing pleural effusion. Pleural effusion may also be caused by an inflammatory exudate from the dilated vessels in the pleura of the irritated diaphragm. Pneumonia may result from retention of infected secretions as a result of hypoventilation of the lower lobes. As in one case in this series empyema or lung abscess can result in a direct perforation of the diaphragm.

All the patients were at one time or another on multiple antibiotics. Three did well on antibiotics alone. Antibiotics can camouflage the abscess and after withdrawal the patient's condition might become worse. This was the case with several patients in our series who developed a sudden onset of fever after antibiotics were withdrawn. There were however three patients with a diagnosis of subphrenic abscess treated *only* with antibiotics with disappearance of their symptoms. Maybe these patients never really had an abscess. Antibiotics might not reach a walled-off abscess

cavity in sufficient concentration to destroy the infecting bacteria. Thus drainage of the abscess is necessary regardless of antibiotic therapy. Drainage plus administration of antibiotics based on culture and sensitivity testing is the most logical therapy.

Fifty per cent of the patients who died in this series succumbed following peritonitis secondary to perforation of a viscus. Of these, one was quite debilitated by uremia and malignant hypertension. The other three died of leukemia, renal failure or septicemia after debilitation from major abdominal trauma. In the absence of debilitation, peritonitis, and septicemia the prognosis seems to be good.

In most patients, in this series, the old incision was opened, especially in those with left sided or subhepatic abscesses. A common approach to right sided abscesses is a transverse incision over the twelfth rib. The rib is partly excised and the cavity is entered extraperitoneally. Three patients were allowed to drain spontaneously. The undrained abscess is a potentially lethal condition and drainage, whether surgical or spontaneous, is the only definitive treatment.

Summary

1. The practical anatomic subdivisions of the subphrenic abscess are right subphrenic, left subphrenic, and subhepatic.

2. Most of the subphrenic abscesses reviewed developed as a complication of a surgical procedure. Splenic surgery leads to a higher incidence than is usually reported. Diseases of the stomach and duodenum accounted for a significantly lower ratio than usually reported.

3. Leukocytosis, fever, and tachycardia were present in 20 of 22 patients.

4. The prominent findings in this series with a right subphrenic abscess were abdominal pain and tenderness, and decreased breath sounds and dullness over the right posterior chest on physical examination, and subdiaphragmatic free air on the chest film.

5. Notable findings in patients in this series with a *left* subphrenic abscess were increased drainage from the operative site, and chest pain.

6. Prominent findings in patients in this series with a subhepatic abscess were abdominal pain and a palpable abdominal mass. Thoracic symptoms were not conspicuous.

7. The subphrenic abscess in this series presented as a thoraco-abdominal complex in 56 per cent of the patients with 77 per cent having abnormal chest x-rays.

8. The mortality rate was 26 per cent in this series. General debilitation, major trauma, generalized peritonitis from a ruptured viscus, and septicemia caused death in these patients.

9. A variety of organisms were grown from the abscesses. E. coli, Staphylococcus and Streptococcus were most commonly cultured.

10. Surgical or spontaneous drainage is the only definitive therapy for a subphrenic abscess. Antibiotics should be given on the basis of the organism cultured at drainage.

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University of Oregon Hospitals

Although we underplay heredity as a factor in any kind of illness, there is one disorder where its role is primary: Huntington's Chorea. And its cost to the community is also underplayed.

Huntington's Chorea

A Case Investigation

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Marion E. Updike, A.C.S.W./Trenton

The classic description of chronic adult chorea by George Huntington in 1872 is still a trade mark of this entity. Huntington[2] emphasized "its hereditary nature," stating that "it is confined to certain and fortunately a few families, and has been transmitted to them, an heirloom from generations away back in the dim past." He also said that, "those exempt from the disease cannot transmit it. It never skips a generation to manifest itself in another. Once having yielded its claims, it never regains them."

Osler[3] in 1894, stated that the disease tended to be transmitted through the male and female alike, with equal involvement of both sexes, although in some families the male appeared to suffer more severely. He felt that heredity was *not* essential since isolated cases occurred in members of perfectly healthy families. But in 1912, Davenport,[1] after examining many pedigrees, found only one exception to the rule that the disease was transmitted solely by one affected by it: that exception was a doubtful case. He felt that Huntington's chorea constituted a typical dominant mendalian trait with the normal condition recessive, and with the affected case *always* derived from affected parents.

Following is a case report about a 29 year old male with nine siblings whose family history was laden with cases of Huntington's chorea.

Generation I

We could not ascertain the presence or absence of chorea in the great grandparents. Both were born in England and later moved to New Jersey. According to relatives, the community in England was "Plumstead Kent."

Generation II

Three of these persons had chorea; all are now deceased. There is evidence that the son of II-4 has chorea. The remaining survivor, II-2, is senile. He shows no evidence of chorea.

Generation III

Cases III-2 and III-3 are still alive with no evidence of chorea. Case III-1 is summarized below.

Generation IV

Of these ten siblings, six have chorea and two have died. Five have been married and four are institutionalized with brain damage or psychosis. The unaffected siblings are living relatively normal lives. Ages of onset of Huntington's chorea in this generation are (in order of birth) 43, 26, 28, 28, 27, 23.

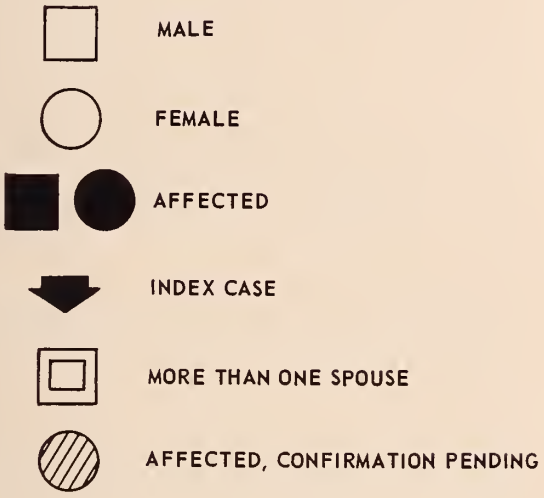
Generation V

The oldest child in this generation is 20 years old. To date, *there is no evidence of chorea in this generation.* Medical information concerning the mental and physical status of each child has been obtained and indicates that only one child requires observa-

* Dr. Fraser is the Coordinator of the Nervous and Sensory Disease Program of our State Department of Health. Mrs. Updike is Director of the New Jersey Consultation Service for Neurologic Diseases. This study was supported by USPHS grant N-3201. The authors thank Mrs. Netty Lowenstein for invaluable assistance in collecting and collating the data for this study.

tion. This child has shown personality changes and has required psychiatric treatment. He is now only 17 years old.

KEY TO FAMILY TREE



Case Histories

CASE IV-9 (Index Case)

On April 4, 1955, this patient was initially examined by the Consultation Service. He was a 20 year old patient who has had seizures for the past 1½ years. These attacks (by description) are of the grand mal variety. In addition, he has minor spells which appear to be abortive grand mal attacks. He had had a childhood attack of meningitis which resulted in complete deafness. His mother suffered from Huntington's chorea. Previous attempts at therapy have included phenobarbital which was given for a while and more recently, he has been on diphenylhydantoin twice a day. Since starting this, he had two minor attacks.

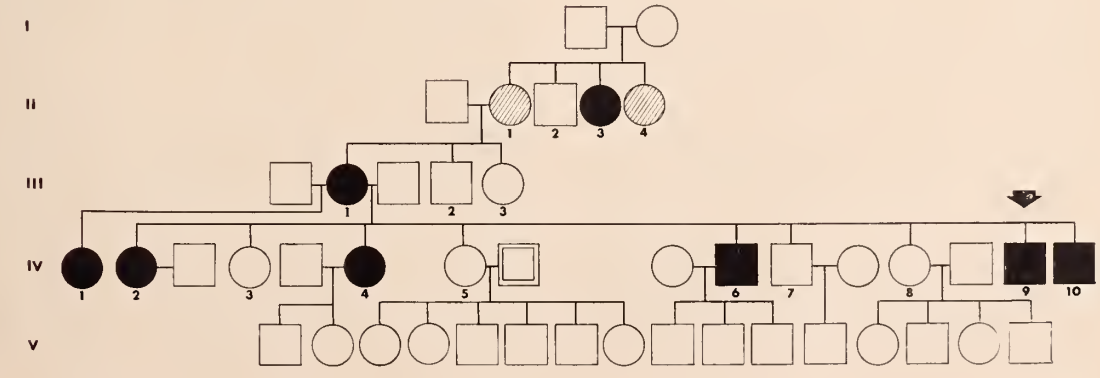
This deaf mute lip-reads very well. He cooperated in the neurologic examination without any difficulty. Cranial nerves were intact except for the eighth nerve which showed bilateral loss of air and bone conduction. Deep tendon reflexes were equal and active; no pathologic reflexes were elicited; and gait and station were normal. He performed coordination tests well. We felt that he was suffering from a convulsive disorder, probably secondary to his attack of meningitis during childhood. An electroencephalogram showed a diffuse abnormality with no focal changes. This record is compatible with a convulsive disorder.

Reexamination by the Consultation Service on October 17, 1955, revealed no seizures since the April evaluation. But here is the report of our June 22, 1964, reexamination:

We had the opportunity of seeing this 29 year old patient in Consultation Service revisit, having originally seen him in 1955, and 1956. The convulsive disorder followed his unspecified meningitis episode in childhood. This has apparently been in complete control since adjustment of his medication to its present level, Mysoline® 250 milligrams t.i.d.; phenobarbital 100 milligrams h.s., and diphenylhydantoin 0.4 Gram daily. The major problem today is his inability to be employed and the necessity for rather constant supervision. This has been amplified during the past two years by a definite change in personality from that of an outgoing, rather pleasant individual. to one who rarely leaves the home, has few outside contacts with anyone, and has become markedly more irritable. This coincides with definite but insidiously progressive unsteadiness of gait, and incoordination in the use of his hands. His mother had died of Huntington's chorea. There is an undocumented story that the patient is one of 14 children, of whom at least two others were so afflicted. We have no detailed medical information on this sibship.

He is a pleasant-appearing deaf-mute, whose gait was wide based, unsteady on turns, but in general well compensated. He had grimacing facial movements and constant writhing, plus adventitious movements of the upper extremities, with poorly performed rapid succession movements and coordination tests. This was also true for the lower extremities. There was no particular laterality. Deep tendon reflexes were active with bilateral Hofmann responses, but flexor plantar responses. The jaw jerk was hyperactive with a moderately positive snout response. Samples of the patient's handwriting revealed incoordination elements

Family Tree



that are stated to be strikingly different than his prior writing pattern. Cranial nerves were intact except for his bilateral deafness. His overall intellectual abilities (within the limits of his deaf-mutism) seemed far below that of prior recorded IQ's in the 120 range.

The patient is considered to exhibit manifestations of Huntington's chorea and to have a well controlled seizure syndrome on his current level of anticonvulsant medication. His basic deaf-mute state is a residuum of his meningitis in infancy. Efforts will be made to identify and secure a follow-up analysis of this individual's siblings with a view toward evaluating their current status and offering genetic counseling.

The patient was hospitalized for a brief period on September 9, 1964 and discharged with the diagnosis of Hereditary Progressive Chronic Chorea with mental deterioration. In May 1965, he had to be committed to a mental institution, as his condition became progressive. As of 1968, the patient is still there.

CASE II-1 Maternal Grandmother

Descriptions of this woman by relatives indicates that chorea existed. She died in a mental institution. Hospital records are not available and a death certificate could not be traced due to inaccuracies in the year of death.

CASE II-3

Documentation of chorea by death certificate reveals that this person was born April, 19, 1888 and died of bronchopneumonia plus psychosis with Huntington's chorea. Both parents were born in England.

CASE II-4

Same comments apply as in case II-1. Relatives indicated the presence of chorea and this patient died in a mental institution.

CASE III-1

Born December 10, 1900; approximate age at onset of chorea: 32. This is the mother of the indexed case. She was hospitalized 1938 with "nervous twitching," jerky, uncontrolled movements. She had difficulty with articulation and an unsteady gait. She was institutionalized in 1940, and died in 1946. Final hospital diagnosis was Chronic Myocarditis with Huntington's Chorea.

CASE IV-1

Born in 1917; Age at onset of chorea "prior to age 43." She is now in a hospital in California, where her condition is described as follows: A memory defect is present but difficult to assess on account of lack of cooperation. There are movements at all times which almost appear stereotyped. The hands, head, and tongue have writhing movements. Diagnosis: Chronic Brain Syndrome with Huntington's Chorea.

CASE IV-2

Born in December 1920; Approximate age at onset of chorea was 26.

In 1943, her eyes began to twitch and there was difficulty in co-ordination. As early as 1946, she was unable to care for herself. In 1956, she was described as destructive and excited with much difficulty in walking, and unable to care for herself. Diagnosis at this time was Chronic Brain Syndrome with Huntington's Chorea and Psychotic Reaction. She died in 1968, having, by that time, been bed-ridden for seven years.

CASE IV-4

Born in 1923; approximate age at onset of chorea was 28. Out-patient notes in 1962 described patient as having choreiform movements with jerks of all extremities. This became worse during a brief span of observation. After the birth of her second child at age 28, patient became increasingly nervous with disturbances in her speech and motion. Her equilibrium was poor and movements were jerky. She was hospitalized in 1963, admitted with burns of the face, back, neck, and chest while trying to light a cigarette causing her clothes to catch fire. She died in March 1963.

CASE IV-6

Born in 1927; approximate age of onset of chorea: 28. Hospitalization in 1961, revealed a 34 year-old male with a 5 year history of irregular, uncontrolled movements of various portions of his body. He certainly had choreiform movements of the head, shoulders, arms and leg. Diagnosis here was Chronic Progressive Chorea with Mental Deterioration.

In December 1965, he was reported as missing. On March 2, 1966, his body was discovered in a river canal. Coroner's report indicates death by drowning ten weeks prior to the autopsy.

CASE IV-10

Born in 1937; approximate age of onset of chorea was 23. He is a known mental defective with an I.Q. in the 40 to 50 range. He ambulates with a striking "chorea" gait with jerky-apparent movements involving the trunk, head, and all extremities. He showed facial grimacing and extremity torsion. Speech was barely intelligible due to choreic involvement. The patient manifested a severe degree of intellectual impairment in all areas.

Summary

A case of Huntington's chorea was investigated by the New Jersey Consultation Service for Neurologic Diseases, revealing many of the sociologic, economic, and medical implications of the disease. The financial impact on the state of New Jersey, created by this family, has been tremendous. More than 70 per cent of these individuals have received state aid through the Bureau of Children's Services or other segments of the Department of Institutions and Agencies.

Medically, the problem is, as it always has been, to develop an effective method of family counseling in hopes of minimizing the propagation of the disease. Stone[4] has stated, "as a social and eugenic problem at the present time, about three hundred years after the introduction of the disease to this country, and sixty-five years after Huntington's treatise was published, the affection appears to be out of

control and challenges psychiatrists, neurologists, and the mental hygiene movement. Prospects of its eradication appear to be remote without adequate legislative measures of the type exemplified by legalized sterilization." This view, although shared by some, would certainly meet with displeasure in many areas.

The procedure for providing formal genetic counseling in this family is in the initial stage of development. In obtaining data on the family, frequent contacts were made with relatives and it was surprising to realize their knowledge of the hereditary aspects of the disease. This investigation has in several respects been of immense counseling value, since our objective in collecting information was fully explained to members of the family in order to obtain complete cooperation.

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John Fitch Plaza

The Trouble With Smoking Is Starting

During the past month, book matches have been distributed by the *Worcester Medical News* throughout the community, state, and nation carrying the message of the caption above, "The Trouble With Smoking Is Starting." The original morbid skull and crossbone seal of the Worcester District Medical Society prominently appears on the match book cover. It serves as a crisp reminder of the indisputable hazards from smoking and is especially geared for the teenager. The glamorous image of the virile young man and sophisticated woman is what seduces the teenager into smoking. After he has begun, the adhesive force of tobacco dependence gains increasing strength. The trouble with smoking is starting.

The medical profession is the most effective leader in the anti-tobacco campaign. However, at times emphasis on the goal has obscured complete insight into the problem. The intelligent adult who smokes appreciates the health hazards. He, and his family, are beset by great feelings of guilt and frustration upon viewing the current anti-smoking television commercials. Furthermore, it is most inconsiderate for hospitals to remove tobacco dispensing machines. Visitors to a hospital are not touring a museum, but rather commonly involved in an emotional strain associated with the illness of a loved one. If the visitor happens to be a smoker then tobacco should be available if desired. It is hardly the time or setting to give up the habit. It is suggested that all hospitals have posters placed in their tobacco dispensing machines which read like the one composed by the Doctor Robert Switzer of the Menninger Clinic: "Members of our staff recognize that cigarette smoking is an extreme health hazard. The use of this machine is not recommended. It is placed here only temporarily until such time that public opinion, based on understanding and acceptance of available facts about the harm done by habitual use of cigarettes, demands removal."

In conclusion, the trouble with smoking is starting. For a copy of the match book, write to Worcester District Med. Society, 57 Cedar Street, Worcester, Massachusetts 01609.

Here are two cases which highlight the value of arteriography in scalenus anticus syndrome — now called "thoracic outlet compression syndrome."

Arteriography In Thoracic Outlet Compression Syndrome*

Nicholas J. Demos, M.D.;
Mahmud V. Bangash, M.D.;
Bernard J. Wattiker, M.D./Jersey City

What has formerly been called the "scalenus anticus" syndrome[4] and now usually termed "thoracic outlet compression syndrome," has slowly been elucidated into a symptom complex consisting mainly of cervicobrachial pain and paresthesia produced by various causes:[1] The syndrome involves one or more of the subclavian vessels and/or the brachial plexus lying in the depths of the posterior cervical triangle. Subclavian arteriogram is a highly specific diagnostic tool, which, when positive, accurately pinpoints the diagnosis. When the arteriogram is negative, it warns the surgeon for the need of further investigation and it excludes a good many etiologic possibilities.

Two experiences, one with abnormal and one with normal arteriogram, will demonstrate the above points.

Case One

A 65 year old woman had an emergency operation for reduction of an incarcerated femoral hernia. While recovering, she complained of left supraclavicular shoulder and arm pain lasting the entire previous year. During the course of her daily activities her left hand would "lose its power." This complaint also had lasted one year. She had a hard mass in the left supraclavicular region over which a forceful arterial pulsation was palpable. Chest x-ray and laboratory studies were reported as normal. On reviewing the chest x-ray a left cervical rib, and perhaps one on the right, were seen. Retrograde brachial arteriogram revealed a stenotic area with poststenotic dilatation in the left subclavian artery. These changes were most accentuated when the arm was placed in the hyperabducted and externally rotated position (Figure 1). The radial pulse became weak in that position but it never disappeared.



Figure 1
Distortion, narrowing, and poststenotic dilatation of left subclavian artery on retrograde brachial angiogram. Note also, a left cervical rib. Arm is hyperabducted. Case 1

In the operating room, through a left supraclavicular incision, a very tense scalene muscle was divided. A cervical rib was excised together with its fibrous attachment on the superior surface of the anterior part of the first thoracic rib (Figure 2). The cervical rib lay

* This work is from the New Jersey College of Medicine and the Jersey City Medical Center, Jersey City. The authors are respectively: assistant Professor of Surgery, Resident in surgery, and Director of Surgery.

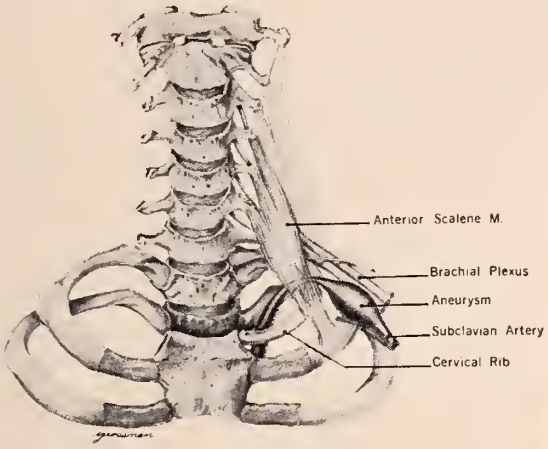


Figure 2

Compression of the left subclavian artery and the brachial plexus by the scalene muscle and the cervical rib. Case 1

under the tensely stretched brachial plexus and the stenotic portion of the subclavian artery. After excision of the cervical rib and division of the scalenous anticus muscle, it was plain that the brachial plexus and the subclavian artery lay comfortably in a soft roomy bed of soft tissue overlying the first thoracic rib. The poststenotic dilatation was not of significant dimensions, and it was not excised.

The patient has remained asymptomatic for over one year. Postoperative arteriogram with the arm hyperabducted failed to reveal the extreme degree of constriction noted preoperatively. (Figure 3).



Figure 3

Postoperative appearance of the subclavian artery. Absence of arterial compression. Case 1

Case Two

A 43 year old woman was admitted with severe pain in the left supraclavicular area, continuous in the last six months and intermittent in the previous six months. She had tingling and numbness in the ulnar distribution of the left forearm and hand. She had been treated unsuccessfully for angina pectoris. She showed some fullness over the left supraclavicular area which disappeared on pressure. Deep pressure over the same area was impossible because of extreme tenderness. There was almost complete absence of sensation over the ulnar distribution of the left forearm and hand. Palpation of either radial or brachial pulse, on either side, was difficult to obtain because of obesity. Retrograde left brachial arteriogram with the arm in hyperabduction through a cutdown revealed normal subclavian artery (Figure 4). Cervical spine x-



Figure 4

Normal subclavian arteriogram. Case 2

rays revealed no abnormality. The neurologic consultant reported a "normal central nervous system." All laboratory work was normal.

Through a left supraclavicular incision, extending laterally and posteriorly, a lipoma was found originating from the posterior rim of the posterior segment of the first rib and ascending between the scapula and trapezius muscle posteriorly, and the brachial plexus anteriorly. The compression and anterior displacement of the brachial plexus was obvious (Figure 5). Postoperatively, the pain disappeared. Sensation in the forearm and hand has shown gradual recovery.

Subclavian arteriogram is of great value in demonstrating the area of compression as well as the status of the artery itself. Compression may occur at the interscalene space (as in our first case) or further laterally when the pectoralis minor is the cause of the com-

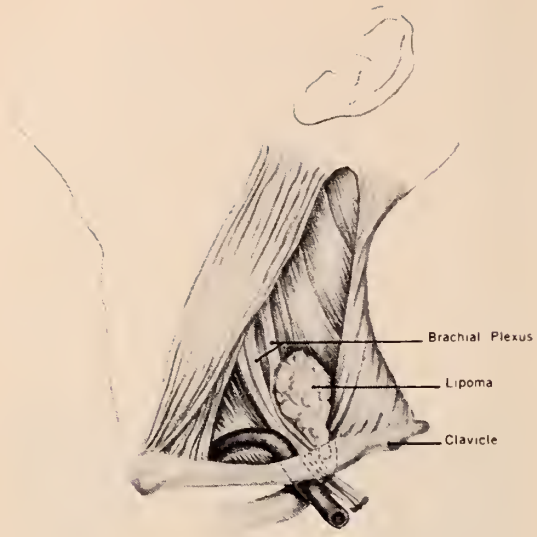


Figure 5

Brachial plexus compression by a lipoma. Case 2

pression. The latter occurs in the hyperabduction syndrome.[1] Whenever the poststenotic dilatation has assumed the proportion of an aneurysm, it should be excised and replaced by a graft.

The arteriogram has to be done with the arm in extreme abduction and possibly external rotation as demonstrated in our first case. In that position the maximal physiologic deformity is reproduced. It is true that in some "normal" cases mild stenosis may be demonstrated. However, severe stenosis with poststenotic dilatation is to be regarded as pathologic.[3]

A negative arteriogram is useful in ruling out the most common causes of the compression syndrome, such as tight scalenous anticus with or without cervical rib or band, hyperabduction (tight pectoralis minor) or costoclavicular compression (pinching of the subclavian vessels between clavicle and first rib). In the costoclavicular syndrome edema of the upper extremity is present and a venogram is useful in demonstrating occlusion of the subclavian vein.[4] In the hyperabduction syndrome, pain is elicited on palpation of the pectoralis muscle just below the coracoid process with the arm in hyperabduction.

Pain of neural origin is described as "pins and needles," has a constant distribution and is almost never accompanied by color change. There is no swelling of the extremity.[1] A meticulous neurologic examination together with special views of the cervical spine should be ordered to rule out a host of neurologic causes of the syndrome. Bateman[1] classifies these purely neurologic lesions as intradural, preforaminal, foraminal, and postforaminal. Certainly, syringomyelia, cord tumors, ruptured intervertebral discs, and osseous and peripheral nerve lesions will have to be ruled out. Angina, with or without evidence of old infarct, should be considered and excluded by a careful history of the pain as strictly "effort pain" and by the electrocardiogram.[2]

Severe anatomic pathology accompanying the cervical compression syndrome should always be treated surgically. If symptoms progress, besides the numbness, coldness, and pain, there are trophic changes of the muscles of the arm, forearm, and hand, and even gangrene. Raynaud's phenomena might be present.

Simple division of the scalene muscle might not be enough in most cases of interscalene compression. Resection of the first rib (and of the cervical rib, if present) has given good results in the hands of Urschel and associates.[5] In our hands, resection of the first rib has not been necessary. However, a tight scalene muscle and/or tendon has to be divided or subtotally excised, and the cervical rib with its periosteum has to be removed. Benign tumors (such as occurred in our second case) offer a good prognosis when removed.

The supraclavicular approach has been found by us adequate in dealing with this problem. The posterior approach, medially to the scapula, as well as the transaxillary route, might be necessary if the first rib is to be resected.

Summary

The value of subclavian arteriography is shown in the preoperative investigation of the thoracic outlet compression syndrome. A lipoma was the very rare cause of the syndrome in the second of our cases.

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24 Baldwin Avenue

Suicidal Behavior As A Child Psychiatric Emergency

Seventy-five children and adolescents presented with suicidal behavior at a general hospital emergency room. Demographic, clinical, and follow-up data of these patients were compared with those of 95 nonsuicidal child psychiatric emergencies. Two thirds of the suicidal patients were girls over 12 years of age. Suicidal boys were more seriously depressed and self-destructive than the girls, regardless of age. Factors such as family disorganization and evidence of long-standing emotional disorder antedating the emergency evaluation were equally common among suicidal and nonsuicidal groups. The self-destructive patients, however, were characterized by a higher rate of hospital admission and extensive aftercare. The suicidal group was discussed in terms of primary motivating factors behind their suicidal intentions, nature of suicidal behavior, lethality of method, and some therapeutic considerations. Frequent observation of typical signs of depression preceded the act by several weeks and made possible suggestions regarding community education in the early identification of the potentially suicidal children and adolescents.

— Mattsson, A., Seese, L. R., and Hawkins, J. W.: *Arch. Gen. Psychiat.,* 20:100 (January 1969)

Leukocyte Antigens In Renal Transplantation

Forty-three patients who had received primary renal grafts from cadaver donors provided the material for this study. In the group there were 19 females; seven had had pregnancies. The total number of transfusions each patient received before grafting was obtained from blood bank and medical records. All these patients were receiving relatively standard immunosuppressive therapy and none had received immunosuppressive therapy before transplantation. Pre-graft sera from 26 recipients were screened for lymphocytotoxic antibodies during the past year. There was no demonstrable relationship between the number of transfusions and the early course of the graft as judged by rejection crises. Of the 26 pre-graft sera examined, three had lymphocyte cytotoxic antibodies. The course of these three patients was interesting in that two had their renal allografts removed within the first three months, while the third has had a poor early course judged by rejection crises. Multiple blood transfusions before renal grafting may sometimes achieve a state of partial tolerance to the subsequent renal graft, but also may result in sensitization.

— Morris, P. J., Ting, A., and Stocker, J.: *Med. J. Aust.,* 2:1088 (December 4, 1968)

The islands of medical specialism need a network of centralized agencies. And here is tomorrow's GP.

The Island Kingdoms

Robert B. Marin, M.D./Montclair

Webster defines an island as a body of land surrounded by water. The analogy between this definition and the present status of medical specialties has evoked much thought. To be sure, the specialist is not new to medicine. There have always been outstanding individuals with unusual perception and ability whose actions and character personify the true use of that title. What was rare in the past has now become commonplace, at least insofar as the title.

The late 20's and early 30's witnessed a significant change in American medicine with the emergence of specialty groups devoted to their own field and dedicated to the preservation of the rights of the doctor primarily as a member of a particular group. This plus the growth of numerous professional guilds produced in medicine a situation analogous to the large university with numerous exclusive fraternities. Suddenly, the fraternities not the university become all important. This was reflected in an alarming division among individuals and hospital staffs. For a time, an M.D. seemed not enough, and the public was quick to sense the change. How healthy this was for medicine, and how helpful for the patient, bears scrutiny. Right now the little man behind the medical eight-ball is both puzzled and perplexed. Should the patient, in a moment of illness, make his own diagnosis and choose a suitable specialist or should he sit for two hours in the waiting room of that rapidly disappearing specimen, the family doctor, and receive a cursory examination and a few pills. He is told that only a full examination, preferably on a yearly basis, is adequate. This he cannot receive in ten minutes from the harassed general practitioner; and to cover thoroughly the anatomy would involve at least ten specialists — hence the dilemma.

It would be unfair to blame any special group for this unhappy state. Medicine, like industry, is passing through a tremendous social and economic transition. In the process, the entire concept of medical care will ultimately change. Most profoundly affected will be the general practitioner, or family doctor. Let it be clear that the change is merely a change in costume. The obvious process of self-limitation in medicine directly parallels the "specialty era" and is further highlighted by the restrictions imposed by hospital boards, particularly on their general practice staffs. It is a reasonable expectation that the general practitioner *per se* will gradually give way to the general specialist or personal consultant. By training, an internist with a sensitive grasp of psychiatry, the personal specialist, will be diagnostician, guide, and medical counselor. He will be the hub of a web covering all branches of medicine and the controlling figure in our personal health problems.

Only by this approach can the confusion and apprehension innocently engendered by the specialist age be clarified and medicine as a whole serve, as it was meant to, the best interest of the individual. If the ultimate decision as to ailment is left to the patient, then we are indeed returning to primitive practices. Dynamic action is needed.

Examine the tremendous contribution made by the American dentist. In two short decades, the patient has been educated to expect the annual and even semi-annual dental check-up. Here, indeed, the story of preventive dentistry has been told so convincingly that we accept our dental summons as a construc-

tive and necessary health routine. The American pediatrician has found the same approach both proper and intelligent in child care. In spite of this, only 25 per cent of all children are under pediatric care and the teeth account anatomically for only 1 per cent of the complex human. From such facts a profound lesson can be drawn.

1. In spite of tremendous scientific achievements, complex machines and antibiotics, we must still deal primarily with the individual.

2. It is better to prevent than prescribe.

3. Nothing replaces the fundamental conclusions drawn from a complete history and a careful physical examination.

4. The ventilation of feelings and fears are imperative to the patient and profoundly informative to the doctor.

5. There is no logical reason why the health supervision practiced by the pediatrician should not be carried into and throughout our adult life.

6. To terminate both counsel and care at adolescence is physically, economically, and socially costly.

It is an unpleasant fact that in an era when medical progress and development have been so fruitful, our profession has seen an evident loss of public regard for the doctor. As a group, we have become apart from our patients. In the vacuum of poor understanding, patient and profession have both suffered.

Examine well the circumstances influencing this trend. Educational requirements, employment practices, professional standing, and hospital rating have become vital social and personal issues. With typical American enthusiasm, a college education has become the trademark of business success and the three to five year residency the hallmark of the specialist. To produce such high priority, finely-ground businessmen or doctors, academic colleges and medical schools have acquired a degree of personal automation which has had a profound effect on our entire educational structure. We have encouraged scientific brilliance at the cost of humanities. In doing so, we have narrowed the spectrum of practical knowledge to an alarming degree.

Gone, for the most part, is that comforting and stabilizing individual, the family doctor. If we are to create and build individual islands of specialization, we must of necessity provide a more adequate system of communication; or, at least, a central bureau of information. By regrooming the general practitioner to fill this important roll, we can provide a necessary service. The success of medical care depends primarily upon the preservation of the individual doctor-patient relationship. He may catheterize hearts, replace kidneys, remove lungs, develop super drugs, and do a host of seemingly impossible things. In spite of this, the most important consideration is that the patient primarily seeks understanding and medical security. To that end, both doctor and patient must be educated to their reciprocal needs. A frank talk with the 1969 patient shows a surprisingly perceptive and informed individual. He knows that a history and physical examination cannot be done in fifteen minutes. He senses that time is still the most important single contribution the doctor makes to the patient. There is further no question of the willingness of the patient to pay for good service. The average American realizes that cheap medicine (like any other cheap product) is a poor investment.

In a crowded, lusty, highspeed, incredibly mobile world, great changes are forecast for United States health patterns. These changes will pose staggering new problems for the entire profession and the individual physician. In a few years, an explosive growth in population is apparent — a five million baby-year, an aging population in which half the working force is over forty years old, a marked westward shift in population, and a large-scale movement from city to suburb. A rapid expansion in the problems of geriatric and chronic diseases is combined with the world population explosion. Tomorrow, diseases of every nature may again become a major concern of the American doctor. To meet this challenge constructively, medicine must reappraise its format for merchandising good health. Only by a vigorous drive based on the fundamentals of preventive care can we be effective. With an enlightened and rededicated general practitioner, the entire facili-

ties of modern medicine will be available to the patient on a sound well-supervised basis. The islands may remain intact professionally, but through intelligent communication and proper guidance be readily available to our patients. United in the common purpose of service, our profession will survive all social and economic changes, and with constructive thought and action animate the future of American health.

85 Park Street

VD and Vision

Vision problems are showing up in a scattering of persons who received penicillin treatment for venereal disease several years ago and were thought to be cured, *The Journal* of the American Medical Association reported in an article in its January 1, 1968 issue.

The report cautions that (1) the organism in victims' eyes hasn't definitely been identified as related to venereal disease, and (2) investigators aren't certain that the organism causes the blurring and partial loss of vision. One thing, however, does seem to be sure: these findings do pose serious questions about the treatment of venereal disease. Finding of the organisms in the eye was first reported by J. Lawton Smith, M.D., of the University of Miami School of Medicine. Later, this was confirmed by Jerome N. Goldman, M.D., of the Retina Foundation, Boston, and by investigators in New York, Philadelphia, Baltimore, and London.

Penicillin has been the main treatment for syphilis for more than 20 years. When given in adequate doses, it usually eliminates all physical signs of the disease. However, Smith and his co-workers have found an organism in the eyes of patients which resembles T. pallidum. They found the organism in the eyes and at 11 other body sites of 100 patients. Thirty of these persons were known to have received "adequate penicillin therapy" and in a few cases, massive doses of penicillin for syphilis. Most of the 100 patients have a history of syphilis. None had any sign of active disease at the time they were examined — except eye and nerve lesions often associated with late syphilis.

Dr. Goldman said he has had some recent, preliminary success in treating approximately 40 such patients with drugs other than penicillin. In most cases, the patients' condition improved within 10 days. Treatment had to be continued 30 to 40 days in a few cases. Leslie Norris of the U.S. Public Health Service agreed on the value of penicillin but asked if it eradicated the organism? "This apparently has been taken for granted since signs of the disease were eliminated. Little consideration was given to the possibility that the treponema may have been sequestered somewhere in the body only to emerge later."

If VD-related organisms do, in fact, "hide" in the body after treatment, it might explain the positive reactions to venereal disease tests some persons display long after they have been treated and signs of the disease have disappeared. In working toward a treatment, Smith is using such a hypothesis, developed several years ago by a French physician, Pierre Collart. Dr. Collart concluded that penicillin sometimes does not destroy all organisms, but that they lose most of their virulence. In early syphilis, Dr. Smith pointed out, T. pallidum is reported to divide every 33 hours. That is why a relatively short course of penicillin treatment — which attacks growing organisms — is effective. But if the organism divides less frequently in late syphilis, penicillin may not be present at the crucial times. (The eye eliminates penicillin relatively rapidly, and it isn't known whether the drug ever reaches the eye's innermost regions.) Thus, says Dr. Smith, "it might be more practical to give antibiotic therapy in more modest doses over a longer period of time."

Perforation by an intrauterine device usually occurs shortly after insertion. Here is reported a rare case of much delayed and apparently spontaneous perforation.

Delayed Uterine Perforation Due To Birnberg Bow:

A Case Report*

Donald R. Reisfield, M.D.;
Eberhard Mueller-Heubach, M.D./
New Brunswick

Studies have indicated that one of the complications accompanying the insertion of an intrauterine device is perforation of the uterus. The device most often related to this complication has been the Birnberg bow.[6,7,9] Most of the papers have suggested that perforation occurred at the moment of insertion. Insertions closely following pregnancy and delivery have also shown to yield a greater incidence of perforation.[6,7,9]

We are presenting this case report to alert the gynecologist to the high incidence of perforation accompanying the insertion of the Birnberg bow. We here record a case where observation over two years seems to document the fact that perforation can occur spontaneously and unrelated to insertion. This report also suggests that removal through colpotomy incision is the procedure of choice.

A 35-year old gravida 6, para 2, who delivered on July 13, 1963, had a Birnberg intrauterine device (IUD) inserted on May 24, 1964. Insertion was accomplished without difficulty. She had pelvic examinations on June 23, 1964, August 27, 1964, and November 19, 1965 because of irregular staining. The cul-de-sac was negative on each occasion. On April 11, 1966 she was seen again for her annual check-up with a complaint of heavy periods. At this visit the device was thought to be felt in the cul-de-sac at the level of the left uterosacral ligament. She was told to use a supplementary method of birth control, and was placed on contraceptive pills. She was again seen on August 2, 1966 for irregular bleeding and the device was definitely felt to be extra-uterine. X-ray of the pelvis revealed the device to be out of the midline, and surgery was scheduled. On October 28, 1966, through a transverse colpotomy, the IUD was seen at the left margin of the incision. It was held by a single fine adhesion to the left posterior surface of the uterus. The adhesion was cut and the IUD removed. Further inspection revealed the uterus and adnexae to be normal. Postoperative course was completely benign.

Recent reports[7,8,9] agree that the Birnberg bow has the highest incidence of uterine perforation. In 34 of 43 perforations reported by Tietze,[9] the Birnberg bow had been inserted. This is an incidence of seven per thousand insertions compared to 0.04 per cent for the other types of IUD's. Of 19 IUD perforations at Columbia-Presbyterian Medical Center, 16 were caused by bows.[7] Reports[4,5,7,8] of intestinal obstruction due to a perforated IUD have appeared and a dramatic picture can occur when the condition is not recognized in time.[5] Scott[8] reviewed 13 reports of intestinal obstruction in which the type of IUD was noted. All of these were the closed type, i.e., 12 bows and one "Incon"® ring.

The risk of perforation with other devices is less than with the bow. De Haan[3] and his staff inserted 100 Margulies spirals and one perforation occurred. Lippe's loops, (currently in greatest use) caused only 13 out of 100 uterine perforations reviewed by Hall.[7] An extraordinary case was reported by Awon.[2] Two loops were removed from the peritoneal cavity by laparotomy after an incomplete abortion. A second loop had been inserted without any attempt to localize the first one

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on the assumption that the first loop had fallen out spontaneously.

To prevent uterine perforations, it is recommended[6,7,9] that the insertion of an intrauterine device should be more than 8 weeks after the last delivery. In 872 reinsertions of IUD's at a more remote date from pregnancy, no perforation was found even though 158 of them were bows.[7]

Most authors[1,6,7] believe that all perforations take place at the time of insertion and that erosion of the uterine wall does not occur. This is suggested by the inverse relationship between the incidence of perforations compared to the experience of the inserting physician.[7] The physician inserting the device in our case had accomplished more than 100 prior insertions. In our patient, the insertion was made ten months after the last delivery but it was not until two years later that the IUD was felt in the cul-de-sac in spite of three intervening pelvic examinations. In only 3 of the 19 perforations reported by Hall was the IUD felt in the cul-de-sac, two were within one month after insertion and the third perforation was discovered 11 months after insertion. The remaining 16 perforations were diagnosed as the patients became pregnant. No symptoms attributable to the perforation could be detected. Our patient became pregnant six times prior to the insertion, and *not* during the two years until the bow was felt in the cul-de-sac. Thus, we are not inclined to believe that the perforation took place at the time of insertion. Spontaneous perforation seems to be more likely.

X-ray showed the device out of the midline in our case. The diagnosis, however, can be missed this way as sometimes the device seems to be still in place on anteroposterior views of the pelvis.[6] A hysterogram is the diagnostic procedure of choice and Esposito[6] even recommends a routine hysterogram one month after insertion.

Removal of the device from its abnormal location is self-evident as intestinal obstruction is not uncommon. In cases without any complications, the approach by a colpotomy incision would seem to be preferred, especially as the asymptomatic perforations indicate that there is no severe surrounding inflammatory reaction.

Summary

In a case of uterine perforation by a Birnberg bow, the insertion was unrelated, chronologically, to the termination of the last pregnancy. The perforation would seem to be spontaneous and unrelated to the insertion. The avoidance of the Birnberg bow as the IUD of choice in current insertions is stressed, but the possibility of spontaneous perforation in bows already in place should be borne in mind by the gynecologist.

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148 Livingston Avenue

A gentamicin sulfate preparation was found remarkably and swiftly effective in treating infected wounds.

A Topical Antibiotic For Industrial Infected Wounds*

Ercole J. Liberi, M.D.;
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Industrial medical departments have long been beset with treating superficial burns, minor wounds, lacerations, and abrasions because of the varieties of infecting bacteria that their patients meet. An antibiotic preparation possessing broad antibacterial activity under such conditions is well worth examining. Recent laboratory and clinical reports on the introduction of a newly developed versatile antibiotic for topical treatment in primary and secondary bacterial skin infections led to a decision to examine the preparation in an industrial complex.[1]

Purpose of the study was to determine the effectiveness of this preparation as an ointment and as a cream in a wide variety of bacterial infections. We selected 50 patients. Pregnant women were excluded, since governmental regulations insist on this exclusion with most new prepartions. The fifty patients were employees of the Owens-Corning Fiberglas Corporation in Barrington, N.J., producers of industrial and commercial home building insulations. Most of them were treated in the plant dispensary. A few were seen in the emergency room for initial therapy. Clinical observations, including description of lesion and degree of pain and discomfort, were recorded before and after treatment. All suspected lesions were cultured. The duration of the investigation lasted a year, ending in December 1967.

In our series, there were 32 primary and secondary skin infections and 18 burns, 12 of which were visibly infected; the remaining cases were suspected of having infections. All patients were male excepting one female patient who was treated for a superficial skin infection as a result of a sand fly bite. The youngest employee treated was 18 years of age, and the oldest, 61.

The ointment was used in 32 patients, and the cream in 18. With one exception, the cream applications were used for lesions of the face.

All were treated as infected burns, lacerations, abrasions, avulsions, and infected allergic dermatitis, and were thoroughly cleansed with soap and water, followed by hydrogen peroxide, and then (as the condition warranted) either the ointment or the cream was applied. A sterile gauze pad then was applied over the lesions and bandaged. Redressings were done daily. For lesions of the face, the cream was used without gauze dressing. Some patients were instructed to return for more frequent applications of ointment and dressings because of the nature of their work, especially those working with grease, dyes, heat, and moisture.

The largest number of infected lesions were in the extremities. Areas involved were:

Arms and hands	34
Legs and feet	9
Head and face	8
Trunk	2
Back	1

The following method was used for culturing

* Dr. Liberi is Medical Director, Owens-Corning Fiberglas Corporation, at Barrington, New Jersey. Miss Sittner is a staff nurse in the Medical Department there.

[1] The new antibiotic was a brand of gentamicin sulfate, 0.1 per cent, tradenamed Garamycin® by the Schering Corporation, Bloomfield, New Jersey.

suspected lesions: A sterile cotton swab was used to swab the lesions thoroughly. The swab was then immersed in a sterile tube containing thioglycollate media which was delivered to the laboratory[2] within 24 hours and placed in an incubator.

Cultures were collected from 41 patients. For minor reasons (changes in work shift, etc.), nine cultures were not submitted to the laboratory. The results (more than one bacterium in some instances) of the culture findings were as follows:

Staphylococcus aureus	22
Staphylococcus albus	13
Streptococcus viridans	1
Streptococcus alpha	1
Streptococcus beta	2
Streptococcus gamma	1
Escherichia coli	1
Klebsiella aerobacter	3
Diptheroid	1
Herella Vaginicola	1
Gram Negative Saprophyte	2
Pseudomonas	2
Bacillus subtilis	1
Bacillus species	1
Aerobacter species	1
No growth	3
Specimen lost	2

Cultures were sterile within 48 hours in two patients and in 72 hours with one. Thirty-eight or 76 per cent of the patients were discharged as recovered within one week (1 to 7 days); of these, 21 per cent (8) were cleared in 48 hours (1 to 2 days); and 79 per cent in 3 to 7 days. Six patients or 12 per cent recovered in 8 to 10 days, and 10 per cent recovered in between 12 and 22 days. The one patient who required 22 days to be discharged was cleared of infection in about eight days but required the remainder of the time for general wound healing. Another patient with severe chemical burns (first and second degree) of the face, trunk, and abdomen showed good clearing within a few days but required further healing time because of the severity of the burns.

Since the dispensary is not in full operation on weekends and the plant operates in three shifts, we were not always able to see these patients on a strictly daily basis. It is likely that in many instances lesions may have healed sooner than reported.

[2] The William V. McDonnell and Associates Medical Laboratories, South Jersey Medical Center, Cherry Hill, New Jersey.

There were no failures in this series.

Illustrative Cases

Patient Number 8 reported to the dispensary on October 4 with obvious lesions of impetigo which had gotten worse since October 1. He could not work because of pain, itching, burning, and inflammation. At least 15 pustules were visible. He was told to cleanse his face thoroughly and to apply Garamycin Cream[1] every four hours. The next day, October 5, lesions were clean, dry, and healing. By October 7, two days later, the face was clear.

Patient No. 64 had Pseudomonas infection (rare Staphylococcus albus — coagulase negative). He had neglected caring for a burn on the left elbow. The first treatment (March 30) consisted of Garamycin Ointment[1] with a dressing over the crusted, purulent area which was indurated and had marked redness. On March 31, he showed marked improvement, less pain, decreased redness, and reduced drainage. Daily redressing was continued. By April 6, the wound was clean, healed, and the patient was discharged as recovered.

Patient No. 12 neglected an infected laceration (Staphylococcus aureus — coagulase positive) of the right fifth finger. Garamycin Ointment[1] was applied to the purulent, painful, inflamed finger on December 27. Redressing was done on December 28 with some evident improvement. On December 29, the markedly improved finger was redressed with no evident exudate. The patient was discharged as healed on January 1, seven days later.

Summary

Fifty patients were treated for infected superficial abrasions, burns, and lacerations with a newly developed versatile antibiotic ointment and cream[1] over a period of one year at an industrial plant. Forty-one of the patients indicated bacterial infections through cultures. More than 75 per cent of the lesions cleared within one week. Lesions cleared in all the remaining patients within 22 days. There were no instances of resistance evident in our series.

The ointment and cream[1] were found to be extremely and rapidly effective as an antibacterial in our small series. Burn infections, particularly, responded extremely well to the preparation. The ointment was easily applied, flowed smoothly with good spreadability. Another important feature was a notable lack of staining.

I recommend that the ointment be packaged in sterile impregnated gauze dressings or an impregnated roller gauze dressing to facilitate application and save time in treating large burn areas.

Owens-Corning Fiberglas Corporation

Patients with possible atrial septal defects should be evaluated early with cardiac catheterization and considered for prompt surgical correction.

Atrial Septal Defect With Pulmonary Hypertension*

Franklyn P. Gerard, M.D.;
Adrian M. Sabety, M.D.;
John S. Madaras, Jr., M.D./East Orange

Pulmonary hypertension, associated with atrial septal secundum defects, increases markedly the surgical mortality in this readily correctible lesion. Dalen and Haynes[7] reviewed 48 patients with atrial septal secundum defects catheterized from 1945 to 1956 and concluded that "surgical correction of even asymptomatic atrial septal defects, uncomplicated by pulmonary vascular disease, a procedure that now can be performed with an operative mortality of less than 5 per cent, would appear to be not only justified but clearly indicated in order to prevent pulmonary vascular disease." In the light of this report, we have reviewed our experiences with six patients with atrial secundum defects and associated pulmonary hypertension (greater than 50 millimeters of mercury.)

Case One

A 40-year old female housewife was evaluated because of retrosternal pain, dyspnea on exertion and palpitations with associated bouts of atrial fibrillation. She had a Grade III systolic murmur heard over the entire precordium especially in the second and third left interspace at the sternal border. The liver was enlarged one finger below the costal margin and the electrocardiogram revealed right bundle branch block with atrial fibrillation. A stethogram showed wide splitting of P-2, fixed and definite systolic murmur. At x-ray, we noticed diffuse exaggeration of the pulmonary vasculature, especially in the central vessels. The cardiac silhouette was enlarged. Cardiac catheterizaton in October 1958 revealed a pulmonary artery pressure of 52. Wedge pressure was 8 millimeters of mercury. Oxygen studies indicated a left-to-right shunt at the atrial level. Open heart surgery was carried out to correct a secundum atrial septal defect. It was necessary to use a patch to close the defect. The immediate post-operative condition of the patient was good. However, a bleeding problem was noted and the patient died ten hours later. The most significant findings of the autopsy were a right hemothorax and passive congestion of the lungs and liver.

Case Two

A 49-year old female was admitted because of increasing dyspnea at rest with associated palpitations. She had a markedly enlarged heart and a Grade IV systolic murmur heard maximally along the second and third parasternal border. X-rays indicated cardiomegaly with predominant right ventricular enlargement. The EKG showed a right ventricular hypertrophy and strain. Catheterization studies reflected a pulmonary artery pressure of 70/20 with indications of a left-to-right shunt at the atrial level. A large secundum defect was closed. Post-operatively the patient had a relatively uneventful course and was discharged three and a half weeks after surgery.

Case Three

A 53-year old male was admitted with a history of "heart condition" of 23 years duration, progressive exertional dyspnea and palpitations. He had a cardiomegaly with a loud systolic murmur heard best over the left parasternal border. X-ray indicated cardiomegaly with marked increase in pulmonary vascular markings. EKG revealed atrial fibrillation with right bundle branch block. Cardiac catheterization disclosed a pulmonary artery pressure of 55/10 with a left-to-right shunt at the atrial level. A right thoracotomy, cardiopulmonary by-pass with hypothermia to 31 degree centigrade was carried out and a large atrial secundum defect was closed without difficulty. He then developed a period of tachycardia followed by bradycardia and arrest. He failed to respond to cardiac massage and repeat cardiopulmonary by-pass. Autopsy did not reveal the specific cause of death other than arteriosclerosis of the coronary vessels.

Case Four

A 47-year old female complained of progressive shortness of breath of over one year duration with associated chest pain, progressive loss of energy and easy fatigability. She had a Grade IV "ejection" systolic murmur heard best over the third left sternal border transmitted to the neck. X-rays showed pulmonary vascular congestion with cardiomegaly. Electrocardiogram indicated right ventricular hypertrophy. Cardiac catheterization revealed pulmonary artery pressure of 100/40 and left-to-right shunt at the atrial level. Through a mid-line sternal splitting incision, cardio-

* From the Ewing Heart Unit, Orange Memorial Hospital, Orange, New Jersey.

PULMONARY ARTERY PRESSURE

Case	*Age*	*Sex*	*Operated*	*Pre-Op.*	*Post-Op.*	*Results*
1	40	F	1951	50/10	—	Expired 24 hours post-operatively. Bleeding problem. Present method of management would have prevented this death
2	49	F	1961	70/20	—	Living and well
3	53	M	1964	55/10	—	Expired on the table
4	47	F	1966	100/40	80/40	Living and well—2½ years
5	35	F	1967	72/26	28/14	Living and well—1½ years
6	21	F	1968	60/24	25/10	Living and well—9 months

pulmonary by-pass was carried out and a large atrial septal defect was closed without difficulty. Post-operatively, the patient required a tracheostomy due to difficulty with tracheal toilette. A wound infection complicated the healing of the sternum and it was necessary to close the sternum with a secondary approach three weeks following the original surgery. The patient went on however to uneventful recovery. She was re-catheterized at the 15-month post-operative period and found to have a systolic pressure of 80 with no evidence of shunt.

Case Five

A 35-year old woman complained of shortness of breath and ease of fatigability. She had a loud systolic murmur heard over the entire precordium with a decided emphasis over the left parasternal border. A diagnosis of atrial septal defect was made precatheterization. At catheterization, the main pulmonary artery pressure was found to be 72/26 and a shunt at the atrial level was noted left-to-right. The surgery was done through a mid-line sternal splitting incision and she went on to uneventful recovery after the closure of a septal secundum defect. The patient was re-catheterized 13 months post-operatively and the pulmonary artery pressure had reduced to 28/14 millimeters of mercury.

Case Six

A 21-year old female was seen in consultation with a history of progressive shortness of breath and recurrent episodes of "pneumonia." She had a loud systolic murmur heard over the entire precordium and best accentuated at the left parasternal border. In addition, there were many inspiratory and expiratory wheezes throughout both lung fields. After hospitalization and a precatheterization period of inhalation therapy (in an effort to decrease some of the lung secretions) a cardiac catheterization was carried out and a pulmonary artery pressure of 58/20 was found with a left-to-right shunt at the atrial level. Pulmonary vascular resistance was noted at 8.5 units. With the use of a cardio-pulmonary by-pass, an atrial septal defect was surgically closed without difficulty. Post-operative course was relatively free of complication. The patient went on to uneventful recovery. Catheterization at the 6-month post-operative level revealed that the pressure had returned to normal.

There is general agreement that surgery is advisable in an atrial septal defect before pulmonary hypertension develops. Mortality in this group is less than 5 per cent reported in 1963 at the American College of Chest Physicians.[6] Quite the contrary have been the results reported in closure of septal defects in the face of pulmonary hypertension greater than 50 millimeters of mercury. Liddle,[4] Swan,[2] McGoon[5] and others have offered reports of mortality from 40 to 75 per cent in this group.

At what point in the life course of this defect will pulmonary hypertension develop? When will pulmonary hypertension become irreversible and thus mitigate against closure of the defect? There are no definite answers to these questions. We note in Case Five, that within one year the pressure returned to normal from a high of 72. On the other hand in Case Four, the arterial pressure dropped only 20 millimeters and would, in general, appear to be irreversible. One might have prognosticated that in this 47-year old female with pulmonary pressure approaching systemic pressure, the changes might be irreversible. However, if the pulmonary artery pressure proved to be reversible, this patient could have been given a new opportunity for life. As it is, her general condition is greatly improved and perhaps when catheterized at the two year period we might learn a little more about this obscure matter of reversible vs. irreversible vascular changes. The dramatic improvement in cases five and six lends great support to our strong belief that *all* of these defects should be closed except in the case of right-to-left shunt.

An aggressive pre-operative preparation with strong emphysis on IPPB therapy has, in our opinion, aided greatly in the survival of these patients. We feel that with this added tool of

therapy, these patients with pulmonary hypertension can be safely operated on. In reviewing our six cases, it is apparent that case one (which was an early experience with this type of problem) expired not from any problem due to pulmonary hypertension *per se,* but rather to a bleeding problem. We feel that with added experience we now would have obtained survival in this patient.

Summary

Atrial secundum septal defects with associated pulmonary hypertension increase the risk of operative mortality. All efforts should be made to correct the septal defect before the possibility of permanent pulmonary vascular changes have occurred. We, therefore, advocate that all patients with possible atrial septal defects should be evaluated with cardiac catheterization and surgically corrected at an early age.

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144 South Harrison Street

Film On Religion And Medicine

A Storm — A Strife is a new 16 mm film produced by the American Medical Association's Department of Medicine and Religion. This 28-minute, sound-color production dramatizes a family's problems with children, health and marriage and draws attention to the need for a physician and a clergyman to work together to serve the "whole" person and the "whole" family and ways to do it. A promotional flyer describing the film in greater detail is available from the AMA Department of Medicine and Religion, 535 North Dearborn Street, Chicago, Illinois 60610.

The department developed *A Storm — A Strife* for the following reasons:

1. To emphasize the concern of the American Medical Association to bring together physicians and clergymen in dialogue.

2. To make available to state and county committees on medicine and religion resource material that would be helpful in a program.

3. To demonstrate how the two professions are drawn together through their common concern for people.

4. To show a situation in which different skills of both professions can be helpful to each other and for the patient.

5. To stimulate doctors and clergymen to think about and discuss both their separate and combined roles in treating patients, particularly those who have a faith.

The movie is intended primarily for use in medical society programing, but also may be obtained by other professional groups and the lay public. It is provided on a loan basis at no charge, except for return shipping costs. It is important to note that, generally, a minimum of 30 days' advance notice is required to insure receiving the film in time for a scheduled meeting or program.

Medical groups may secure a print of *A Storm — A Strife* from the AMA Film Library, 535 North Dearborn Street, Chicago, Illinois 60610. Non-medical groups should direct their requests to Modern Talking Pictures Service, Inc., 1212 Avenue of the Americas, New York, New York 10036.

Aortia angiography offers a valuable and comparatively non-traumatic diagnostic tool in pheochromocytoma.

Pheochromocytoma: Intra And Extra Adrenal*

A Report of Two Cases

Marvin R. Agran, M.D.;
E. Arthur Kratzman, M.D.;
Michael M. Lazorek, M.D./Plainfield

In recent years, suspicion of pheochromocytoma has been substantiated and pre-operatively suggested by angiographic technics. Because this tumor is usually not palpable and may be unilateral, bilateral, or extra-adrenal in origin, the method used to localize this tumor for the urologist becomes ever more important. We will discuss the usefulness of the angiogram to the clinician and urologist in the two cases to be reported and hope that its many benefits will become more easily recognizable and acceptable.



Case I: Figure 1. *Extra-adrenal pheochromocytoma* (malignant). Selective right renal arteriogram in early arterial phase shows a prominent, large, and concave displaced inferior adrenal artery without an increased number of vessels or blush to the right adrenal gland.

* This work is from the Muhlenberg Hospital in Plainfield, New Jersey where Dr. Kratzman is Director of Radiology, and Doctors Agran and Lazorek are Associate Radiologists.

Case I—Extra-Adrenal

A 34 year old woman with a long history of hypertension was admitted with a blood pressure of 180/120, after having been started on anti-hypertensive medication when her blood pressure was 260 140. Past history revealed headaches, palpitation, dyspnea, and toxemia in pregnancy. She never was in pulmonary congestive failure. She was unable to perform her everyday activity due to headaches, palpitation, and dyspnea. There was no peripheral edema, liver, or spleen enlargement. Laboratory studies showed elevation of the blood sugar to 155, and elevated PBI with positive catecholamine studies. VMA 24 hour study was 55 with a normal control of 0.7-6.8 used. Chest x-ray showed no cardiac enlargement or congestion.



Case I: Figure 2. Sequence film in late arterial phase shows an increased number of vessels in the right sympathetic chain area adjacent to the right adrenal gland without blush or stain. These vessels represent increased blood flow to the extra-adrenal pheochromocytoma.

Intravenous urogram showed normal functioning kidneys and no calcification. Renal aortogram and selective bilateral renal arteriogram studies revealed normal size adrenal glands, vessels, and normal adrenogram phase. However, increased vessels with stretching adjacent to the right adrenal gland were noted. (Case 1, Fig. 1, 2, 3) The increased vessels were primarily around the right para-aortic and sympathetic area suggesting extra-adrenal pheochromocytoma. Surgery revealed a non-resectable tumor adjacent to the right adrenal gland involving para-aortic nodes which flattened the adrenal gland. The tumor extended around the aorta, vena cava, across the midline to the head of the pancreas and into the porta-hepaticus. Biopsy revealed a malignant extra-adrenal pheochromocytoma.



Case I: Figure 3. Sequence film in late venous phase shows no "adrenogram, blush, or stain." A flattened adrenal gland is noted.

Case II—Intra-Adrenal

A 52 year old woman was admitted for the fourth time with pulmonary edema. Past history revealed palpitation, nausea, vomiting, dyspnea without arrhythmia on her previous admissions. Peripheral edema was never present and heart size was always normal. Between attacks, she lived an active existence and never had chest pain. She was a thin woman in acute respiratory distress with dyspnea and palpitation. Blood pressure was 150/90, and respirations were 28. Liver and spleen were not enlarged. Blood sugar was 150. All other tests and kidney function studies were normal. Chest x-ray showed no cardiac enlargement, but pulmonary congestion with a central "butterfly" appearance was noted, consistent with uremic congestion. Intravenous urogram was normal. In view of normal VMA and catecholamine studies, a renal aortogram was performed. (Case 2, Fig. 1, 2) This revealed a large left adrenal gland with arterial changes and a specific venous adrenogram phase indicative of pheochromocytoma. On the operating table a left adrenal mass was removed weighing 57 Grams, measuring 6 by 5.6 by 2.5 cm. The pathologist reported a benign pheochromocytoma.

Discussion

The adrenal gland is fed by three main suprarenal arteries:[1] the superior adrenal branch



Case II: Figure 1. *Left adrenal pheochromocytoma* (benign). Arterial phase abdominal aortogram shows an increased number of small vessels to and around the left adrenal gland.



Case II: Figure 2. Sequence film in late venous phase shows "an adrenogram, blush, and stain" of an enlarged left adrenal gland.

from the inferior phrenic artery; the middle adrenal branch from the aorta; and the inferior adrenal branch from the renal artery.[2] These vessels which feed the normal adrenal gland are usually small and difficult to detect.

In many patients,[3] these main vessels show a variable origin. When the adrenal gland or adjacent sympathetic chain is infiltrated and enlarged by tumor tissue, the demand for blood is increased. This causes the normally small vessels to increase and enlarge in number and size and become visible during arteriography. With our malignant extra-adrenal pheochromocytoma, the tumor extended adjacent to the right adrenal gland and around the aorta. The usual reticulated network of the small arteries localized within the benign adrenal pheochromocytoma with its attendant "hypervascular faint blush" in the capillary phase were absent.[4] (Case 2. Fig. 1, 2). Instead, a prominent, enlarged stretched and displaced inferior adrenal artery was noted with an increased number of smaller vessels visualized around the sympathetic chain. (Case 1. Fig. 1, 2, 3). These findings become very significant when one realized from other reports that about 10 per cent of all pheochromocytomas originate in extra-adrenal locations.[5] This requires a more careful radiographic study of the sympathetic chain to visualize these abnormal vessels.[6,7]

In a review of the medical literature since 1958, Boijsen *et al.*,[9] reported that 6 out of 42 patients who had arteriographic studies developed a hypertensive crisis during this procedure. These were all easily controlled with injections of phentolamine.† We too found that this crisis effect did occur during aortic angiography and selective catheterization of the right renal artery with no crisis occurring during direct injection of the opposite renal artery.

† Phentolamine is available under the Ciba tradename of Regitin.® This is an antiadrenergic drug.

Conclusions

In either form of pheochromocytoma, selective renal and abdominal aortic angiography offers a more complete diagnosis with less trauma than either translumbar arteriography or retroperitoneal pneumography, and will probably become the principal radiographic procedure for diagnostic investigation.

Acknowledgements: To Mrs. Nancy Tumminello and Miss Patricia Adler for secretarial services, and to Mr. Warren Vroom for the photographic assistance.

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NEW JERSEY DOCTORS' NOTEBOOK

Address of Retiring President*

John F. Kustrup, M.D.

In this past year, I made many trips between Trenton and Newark, using Route 1 between Trenton and East Brunswick, and the New Jersey Turnpike from East Brunswick and Newark.

For a good part of the year, Route 1 between Landis Circle and East Brunswick was under repair. Traffic was slowed on many occasions but it did creep along. Finally, the road was widened but during the busy hours, tie ups were chaotic because drivers would approach each other at all angles in their anxiety to reach their destination. Not until traffic lines were painted in, did traffic move in an orderly fashion, and at the proper speed consistent with the quality of the road.

The Presidency of a busy organization is like this. One president takes over from another, leaving part of the program to be completed by his successor, drawing proper and distinct lines, in the hope that the transition will be orderly and the programs continuous and progressive.

What was accomplished, in this year, as your president — an experience for which I am most grateful and through which I have learned to respect you more?

In my presidential report you will find a detailed accounting. My visits to meetings of our county societies, neighboring state societies and national meetings were of great interest. I attended most council and committee meetings, every Board of Trustees meeting, meetings of allied professions, the legal profession, and paramedical groups, with members of government, national and state, including the Governor, and the lay public.

My aim, always, has been to express what I believed were your wishes. Perhaps you will be interested in a few comments from me on selected subjects of common interest.

House of Delegates and Board of Trustees: In most houses of delegates and boards of trustees, the personnel is of the 55-65 year group. This should be altered. There should be a more adequate admixture of younger men, so that we may blend the experience of middle aged and older men with the eager earnestness and lively zeal of the young.

Specialty Societies: Members of specialty societies should become more involved in the county and state medical society activities. We are first of all physicians, then specialists. Our opinions are needed for proper evaluation of problems related to our specialty and for application of our specialty to medicine as a whole. In return, Medicine will be better able to deal with our problems if it has the benefit of our exposition of them.

Liaison with Government, Industry, and Labor: Medicine must have better liaison with government, industry, and labor.

Today all are interested in the quality of medical care and, of necessity, the cost of medical care. Had better liaison existed in the past between Government and Medicine, Government would have had a clearer knowledge of the physicians' vast charitable contribution of health care to the community.

Had there been better liaison with industry, industry as a whole would more willingly have participated in voluntary health plans and pensions for its employees.

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* Presented before the House of Delegates, first session, May 17, 1969.

An important cause of higher cost of health care is the increased wage scale of hospital employees. Labor costs comprise 65 to 70 per cent of hospital expense and only 28 to 52 per cent of industrial expenses.

With improved communication among these groups, we can avoid controversies based on ignorance, which produce nothing constructive and do little to help attain the goals we all strive for — better care for all patients at reasonable cost.

Legislation: In attempts to support and have enacted legislation which is of interest to the health and welfare of the State, we were not always uniformly successful. We made progress in most items which we considered important. I believe that our physician members, because of their interest in Medicare and Medicaid, have become more knowledgeable on legislative matters and have come to enjoy a greater degree of participation in the Society than at any other previous time in our 203 year history. In Medicaid our recommendation was that a qualified insurance carrier be designated to process claims, and that payment for medical services be made on the basis of usual and customary charges. We also recommended an eventual inclusion of the medically indigent. It is well to remember that it is easy for the legislature to promise care but it is another thing to supply it. The production of medical and paramedical personnel and the expansion of hospital facilities cannot be hurried if quality care is sought.

Relative Value Scale: In view of the controversies with reference to usual, customary, and reasonable fees, I recommend that a study be made regarding the development of an updated relative value scale, and the eventual implementation of it.

Comprehensive Health Planning: PL89-749 is concerned with the physical, mental, and environmental health needs of the total population. Physicians should organize at county level or by judicial districts to plan the details of local health needs for their areas. On this keystone can be established a partnership in health which will bring into closer relationship the resources, skills, and abilities of the public and private sectors at state and local levels.

The plan, for the present, is to continue to supply the best care that can be had with the available personnel and facilities, and for the future to expand medical care to meet the needs of everyone. The supply of physicians and of all paramedical personnel must be increased. The hospital inpatient and outpatient facilities must be expanded, and arrangements made for continued education of all medical personnel and peer review.

The public must be trained in the proper utilization of physicians and hospitals. Physicians must assume leadership in environmental health and preventive medicine.

Education: Gaps which separate practicing physicians, medical faculties, and students must be closed. Graduate education and continuing education of the physician must be reemphasized. The Academy of Medicine of New Jersey, under sponsorship of The Medical Society of New Jersey, is acting as our Society's educational arm to bring educational programs to physicians in hospitals throughout the state. We urge you to participate.

Good health cannot be maintained by the medical profession alone, without the simultaneous improvement of conditions under which many economically distressed individuals live. Improved housing and education are of equal importance.

Education must be directed to make the greatest use of that intellect which an individual possesses. A person placed in a field of endeavor which is beyond his mental and physical capacity will become depressed or rebellious. He will be happy if placed in a job he can do well.

Therefore, we should supply a means of education to equip each individual for that field of work for which he is best qualified. Work, not welfare, leads to hope, self-respect, and dignity — to good mental and physical health.

I will always treasure this experience as president. It increased my respect and esteem for those who held office before me. It prompts me to wish greater success than any of us to this time have accomplished to our successors in this high office.

I urge all the members of our Society to become more active in state and county society affairs and to have their wives become active members in the Woman's Auxiliary. Please participate for your health as a physician and for your patients' health.

The loyalty and industry of our officers, Board of Trustees, Judicial Council, this House of Delegates, our councils and committees, and the entire membership deserve special commendation. Your work made mine easy.

I am grateful to the Woman's Auxiliary for its contribution to our efforts and for the privilege of having Mrs. Kustrup serve as its first officer during my presidency.

Our office staff works, inconspicuously, in great harmony — efficiently and zealously. Without their great effort, we could not function. To them, I say thank you.

My expression of gratitude to our Executive Director, Dick Nevin, has been purposely saved for this moment. In all our neighboring states, as in all of our county societies, he is admired and respected for his ability as an outstanding executive and gentleman. He is a devoted friend of mine and of all of you in this Society.

Good health is a most treasured gift. Let us be leaders in getting good health care to our communities, in determining future patterns of health care. We are best equipped of all citizens to do this.

I thank you for the honor you bestowed on me as your president. I hope, as your 176th president, I have brought equal honors to you.

Trustees' Minutes

April 20, 1969

A regular meeting of the Board of Trustees was held on April 20, 1969 at the Executive Offices in Trenton. Detailed minutes are on file with the secretary of your county medical society. A summary of the significant actions follows:

Union County Medical Society Centennial . . . Directed that a commemorative citation be presented to the Union County Medical Society at its centennial celebration on June 7, 1969; and that the same format be followed for other component societies celebrating their centennials in the future.

Nursing Home Association Proposal For Advisory Council . . . Agreed to participate in an Advisory Council (with no financial commitment) together with representatives from the Prudential Insurance Company, Blue Cross, New Jersey Hospital Association, and Nursing Home Association to promote better understanding between fiscal intermediaries and the providers; to promote educational programs; and to exchange ideas and suggestions.

Council On Legislation . . . Approved, as amended, the report of the April 17 meeting of the Council on Legislation, including the following recommendations:

1. That the reason for disapproval (of S-211) be approved as the official position of MSNJ.

The recommendation resulted from a report of the Council members designated to investigate the background of S-211 (to authorize the issuance of limited licenses to practice medicine and limited licenses as assistants in medicine) which stated:

The Council reaffirmed its position of "disapproved" for the following reason:

Disapproved as undesirable and unnecessary because interns and residents are presently not required to hold licenses as physicians and surgeons to serve in hospitals in New Jersey. No licenses should be granted to other than demonstrably qualified persons who have met the requirements of the Medical Practice Act.

2. That MSNJ adopt as its official position the actions indicated on the following bills of medical significance.

S-561—To define, under the Hazardous Substances Labeling and Sales Act, the term "label" as applied to an unpackaged article; the term "misbranded package" to include a child's toy and to provide a definition for "banned hazardous substance." *APPROVED*

S-567—To increase maximum weekly workmen's compensation benefits to $90 for permanent total and temporary disabilities and death benefits; to increase permanent partial disability weekly benefits to $45; to provide increased benefits for amputations and enucleation of the eye; to provide for appointment of judges of compensation by the Governor with advice and consent of the Senate, to provide for lump sum settlements and other amendments. *NO ACTION*

S-570—To provide hospital, medical, surgical and major medical expense benefits for State employees and their dependents and to permit a refund from the State Health Benefits Commission to an employee of an employer other than the State whose spouse is also an employee of an employer other than the State where the spouse is enrolled as a dependent and the employee is required to pay the full cost of dependent coverage. *NO ACTION*

S-586—To require trustees of the New Jersey Medical and Dental College to appoint employees in accordance with provisions of Title 11 Civil Service. *NO ACTION*

S-599—To provide that in approving dental x-ray technology the board shall take into consideration standards adopted by the American Dental Association for training dental hygienists and dental assistants. *APPROVED*

S-641—To provide for issuance of certificates for the operation of air pollution control equipment or apparatus in dwellings where such can be operated without violating any pertinent codes or regulations and if such equipment incorporates the latest advances in control technology. *APPROVED*

S-642—To define "area" in the Air Pollution Emergency Control Act to mean only that portion or portions of the State described in the Governor's air pollution emergency declaration. *APPROVED*

S-643—To authorize the Clean Air Council to establish an *ad hoc* joint technical committee of 7 members with power to promulgate rules and regulations. *DISAPPROVED,* because there is no evidence at the present time that the control now exercised by the Department of Health is not satisfactory and that the personnel of this proposed *ad hoc* committee would be as well informed in the control of air pollution as is the Department of Health.

S-646—To provide for the establishment of air pollution control commissions in the counties. *DISAPPROVED,* because there is no evidence at the present time that the control that is now exercised by the Department of Health is not satisfactory and that the personnel who would control these committees would be as well informed in the control of air pollution as the Department of Health. Moreover, the prevailing unified control would be jeopardized.

S-661—To put the Division of State Medical Examination in the Department of Health, removing it from the Department of Law and Public Safety and to provide for supervision by the Commissioner of Health in place of the Attorney General. *DISAPPROVED,* because by far the greatest part of the work of the Office of the State Medical Examiner lies in the area of law enforcement and police investigation and is more proper to the Department of Law and Public Safety than to the Department of Health.

S-669—To establish the "New Jersey Pure Water Bond Act" authorizing issuance of bonds, after referendum, in the amount of $304,850,000 for water supply and water treatment facilities. *NO ACTION*

S-689—To exempt from the restrictive provisions of the New Jersey Industrial Home Work Law those persons homebound because of advanced age, physical or mental disability, injury or illness; to provide for medical certification of ability; to establish that the N.J. Rehabilitation Commission, N.J. Commission for the Blind or other agency recommends employment; to authorize the Commissioner of Labor and Industry to promulgate rules and regulations and other amendments. *APPROVED*

S-721—To require the Commissioner of Institutions and Agencies to establish a program of education in the legal, sociological, medical and psychological aspects of the prevention and control of drug abuse and narcotic addiction to be administered by his Department. *APPROVED*

S-725—To provide for continuation of facilities to educate handicapped children through the summer months; to define "atypical pupils" to include those classified as handicapped and include pupils of ages 3 through 20 years. *APPROVED*

S-727—To permit subscribers to medical service corporations the benefit of physical therapy services performed by a registered physical therapist elsewhere than in a hospital. *APPROVED*

A-127—To define a "depressant or stimulant drug" to include any hallucinogenic drug, including d-lysergic acid diethylamide (LSD), n-n-dimethyltryptamine (DMT) psilocybia, mescaline, peyote, bufotenin, epena, parua, ayahuasca, yage, caapi, amaneta muscaria and other substances; and to provide penalties. *APPROVED*

A-270—To provide for the mandatory civil commitment of drug addicts and to establish a procedure therefor. *APPROVED*

A-372—To provide that when an applicant for a nurse's license has been previously licensed or registered under the laws of another state, territory, possession of the United States or any foreign country, the examination shall be limited to subjects prescribed by the New Jersey Board of Nursing and not covered in the initial examination.

On March 6, 1969 the Council deferred action on A-372 pending a reply from the State Board of Nursing. This Board has now stated their opposition to this measure. The Council now takes a position of *Disapproved,* in support of the position of the State Board of Nursing; and because it would impair the uniform standards for licensing nurses in New Jersey.

A-582—To establish a Division of Medical Care Facilities within the Department of Health with comprehensive responsibility for the development and administration of State policy with respect to hospital and related medical care services in all public and private institutions. *DISAPPROVED, WITH ACTIVE OPPOSITION IF BILL MOVES,* because it poses a threat to the free practice of medicine and the continued life of the Medical-Surgical Plan of New Jersey.

A-614—To provide that the requirement of a certificate under the act concerning regulation and certification of x-ray technicians shall not apply to licensed dentists and persons who operate, under a licensed dentist's direct supervision, only x-ray equipment designed for dental radiographs. (Amends A-660 of 1968—approved) *APPROVED*

A-618—To provide that nothing contained in the Workmen's Compensation Law shall be construed to render immune from liability under the common law or otherwise, on account of an injury or death, any person who at the time of the injury or death was in the employment for the same employer as the person injured or killed and who engaged in the practice of medicine. (Companion to A-633 of this year.) *DISAPPROVED,* because it discriminates against doctors of medicine among licensed practitioners of the healing arts and does not restrict the liability to acts of professional service.

A-628—To exempt over-the-counter drugs recommended and generally sold for the relief of pain, ailments, distresses or disorders of the human body from the Sales and Use Tax Act. *APPROVED*

A-633—To provide that nothing contained in the Workmen's Compensation Law shall be construed to render immune from liability under the common law or otherwise, on account of an injury or death, any person who, at the time of the injury or death, was in the employment of the same employer as the person injured or killed and who engaged in the practice of medicine, surgery, dentistry or chiropractic. (Companion to A-618 of this year.) *APPROVED*

A-638—To require disclosure of generic and brand names on prescription drugs, compounds and medicines. *APPROVED*

A-657—To require all passenger automobiles to be equipped with ventilation systems while the motor is running effective July 1, 1970, of a type approved by the Director of Motor Vehicles. *APPROVED*

A-663—To increase penalty for violation of health ordinances to imprisonment for 90 days or a fine of $1,000 or both. *NO ACTION*

A-664—To establish presumptions in certain illnesses of firemen and policemen. *DISAPPROVED,* because it involved diagnosis by legislative enactment rather than by medical investigation.

A-670—To include carbon tetrachloride in the phrase defining "glue." *APPROVED*

A-677—To establish penalties for violations of the motor vehicle laws when a person is convicted of violations while under the influence of alcohol or narcotic or habit producing drugs. *NO ACTION*

A-688—To provide that if perishable items are in package form they shall contain a label in 12 point type which shall read "do not use after" followed by a date. *APPROVED*

A-690—To provide that grounds for refusal to grant or suspend or revoke licenses to practice medicine, surgery or chiropractic shall include violations of any provision of the act or any rule, regulation, code of ethics promulgated by the Board of Medical Examiners; or where a practitioner is found guilty of unprofessional, dishonorable or unethical conduct. *DISAPPROVED,* because it is the proper function of the State Board of Medical Examiners to enforce the rules and laws governing the practice of medicine, and it is the province of the profession of medicine itself to enforce conformity with principles of ethics and standards of professional conduct.

A-703—To increase penalties for violations of health ordinances. *NO ACTION*

A-708—To provide for dating of frozen foods; to require the Department of Health to promulgate standards for maximum lengths of time various foods may be kept frozen without damage to healthfulness, nutritive value or palatibility. *NO ACTION* (Doctor Johnson voted in the negative and asked to be so recorded.)

A-713—To provide that no person may fabricate or sell eyeglasses or sunglasses unless fitted with plastic or glass lenses which are tempered and case hardened with minimum thickness of 2 millimeters; and to prohibit cellulose nitrate or other highly flammable frames. *NO ACTION*

The Board amended the position of the Council concerning A-713 to one of *APPROVED.*

A-758—To provide that the term "depressant or stimulant drug" shall include any hallucinogenic drug; to prohibit possession of such drugs by unauthorized persons. *APPROVED*

A-776—To authorize the Commissioner of Health to establish and operate community health centers under the "Community Health Center Demonstration Act." *NO ACTION*

A-811—To provide that no commercial licensee shall collect blood for transfusions and pay a con-

sideration therefor unless, prior to phlebotomy, the donor is examined by a physician. *APPROVED*

A-819—To establish the Clean Water Treatment Bond Act providing for a bond issue of $20,000,000 for controlling and eliminating pollution of streams, lakes, waterways, bays and other tidal and surface waters by acquiring and constructing public water treatment facilities. *NO ACTION*

A-820—To provide for 9 in place of 5 nursing home administrators on the Nursing Home Administrators Licensing Board, two of whom shall be administrators of governmentally operated nursing homes and two shall be from non-profit homes for the aged with licensed infirmaries. *NO ACTION*

A-842—To appropriate $100,000 to the State Mosquito Control Commission for transfer to the Agricultural Experiment Station for mosquito control research. *NO ACTION*

ACR-65—To create a commission to study the use, sources, and trafficking in narcotic and hallucinogenic drugs in high schools, colleges, and universities. *APPROVED*

3. The following bills were noted and filed, as not being of intimate concern at this time.

S-564—To exempt from tax all real and personal property owned by a joint labor-management trust fund for the purpose of establishing or operating a non-profit medical clinic. (Similar to S-202 of this year — note and file.

S-631—To provide that a board of education is not required to provide further educational programs for pupils in the Marie H. Katzenbach School for the Deaf but shall be required to furnish transportation to and from such school.

A-726—To permit the Director of Motor Vehicles to authorize attendance of a driver subject to suspension or revocation of a driver's license to attend a Driver Improvement School, in lieu of all or part of a period of suspension in first violations of speeding in excess of 10 miles over the legal limit or where there has been an accumulation of 12 points within a 3 year period.

A-730—To provide that State established statutes, codes, rules, or regulations establishing standards concerning processing, packaging, storage, distribution, or sale of food for human or animal consumption shall supersede any county, municipal or health district ordinances, codes, rules, or regulations inconsistent therewith.

Statement on Delivery of Medical Care Services . . . Recommended that the Board of Trustees endorse, in principle, the resolution from the Connecticut State Medical Society — "Guiding Principles *Re* Delivery of Medical Care Services" — and that the Society be so informed.

Council on Public Health . . . Approved the report of the March 19 meeting of the Council on Public Health including the following recommendations:

1. That the name of the Special Committee on Air Pollution Control be changed to the "Special Committee) to recommend that all county units appropriate administrative year, 1969-1970.

2. That MSNJ urge the New Jersey Division of the American Cancer Society (through its medical committee) to recommend that all county units appropriate funds for the purchase of a manikin for the purpose of instructing physicians in performing routine sigmoidoscopies.

Finance and Budget Committee . . . Approved the report of the Committee on Finance and Budget, including recommendations to the 1969 House of Delegates. The entire report is included in the Committee's Annual Report and will be submitted to the 1969 House of Delegates, and is, therefore, not reprinted here.

Medical Student Loan Fund . . . Approved the report of the April 20 meeting of the Committee on Medical Student Loan, including the following recommendation:

That the Medical Student Loan Fund Account (E-6) be reduced from $13,000 to $5,000 for the 1969-70 budget, and that the appropriation be turned over to the Medical Student Loan Fund only as the Chairman of the Committee expresses a need for the funds.

Publication Committee . . . Approved the following recommendation, which is in accord with the provision of the contract with Periodical Press Corporation for increasing rates in connection with the publication of *The Journal*:

That the Board of Trustees approve the 8 per cent increase, effective with the April 1969 issue; and that the two copies of the price addendum be signed and returned to the Printing Corporation of America.

Medical Advisory Council to Medicaid Commission . . . Directed that the name of Louis K. Collins, M.D. of Glassboro, be submitted as MSNJ's official representative on the Medical Advisory Council of the State Medicaid Commission.

Secretary Pro Tem . . . Appointed Louis F. Albright, M.D., of Spring Lake, to serve as

Secretary *Pro Tem* through the 1969 Annual Meeting.

AMA-ERF Allocations . . . Received the information that AMA-ERF allocations to Rutgers Medical School ($2,433) and the New Jersey College of Medicine ($5,629) will be presented at the House of Delegates on May 17.

New Jersey Blood Bank Association . . . Designated Dr. David Eckstein as official representative of MSNJ on the temporary executive committee (formerly the *Ad Hoc* Committee on Blood Banking) of the New Jersey Blood Bank Association.

Allergy Testing In The Practice Of Medicine

In February of this year the Board of Medical Examiners revoked the license of an allergy testing laboratory which was doing these tests without medical supervision. The Board was unmoved by the allegation that the laboratory was simply a consultant to the referring physician.

In this case the layman and his employees did skin tests and even dispensed a treatment mixture.

Physicians who send patients to lay-operated, medically unsupervised laboratories are advised that such reference may be construed as unethical and, as indicated by the recent State Board action, may result in the revocation of the laboratory license.

AMA Convention

July 13-17 New York

Headquarters—Americana

Scientific Meetings and Exhibits

New York Hilton and The Coliseum

Veterans Administration Raises Psychiatric Fees

Effective April 3, 1969, the fee schedule applicable for services rendered to Veterans Administration patients by psychiatric specialists has been revised as follows:

Full psychotherapy session (50-60 min.) — $25

Half psychotherapy session (25-30 min.) — $15

Limited psychotherapy session (5-15 min.) — $7.50

The foregoing changes were brought about through the cooperative efforts of The Medical Society of New Jersey, the New Jersey Neuropsychiatric Association, and the Veterans Administration.

Restructuring Of TB Organizations

The Tuberculosis-Respiratory Disease Association of New Jersey announces that our State is now being served by five regional organizations, in addition to the statewide Association, whose headquarters are located at 2441 Route 22 in Union, New Jersey. The five regional headquarters are:

Hackensack—Tuberculosis-Respiratory Disease Association of Bergen and Passaic Counties
369 Union Street
Hackensack, New Jersey 07601

Jersey City—Tuberculosis-Respiratory Disease Association of Central New Jersey
12 Baldwin Avenue
Jersey City, New Jersey 07304

Princeton—Delaware-Raritan Tuberculosis and Respiratory Disease Association
Lower Alexander Road
Princeton, New Jersey 08450

Orange—Essex-Northwest Tuberculosis-Respiratory Disease League
96 Main Street
Orange, New Jersey

Pleasantville—Tuberculosis-Respiratory Disease Association of Southern New Jersey
137 South Main Street
Pleasantville, New Jersey 08232

Communicable Diseases In New Jersey

The following communicable diseases were reported to the Division of Preventable Diseases during the month of April:

	April 1969	April 1968
Aseptic Meningitis	16	11
Primary Encephalitis	2	5
Post-Infectious Encephalitis	0	1
Hepatitis: Total	181	119
Infectious	153	108
Serum	27	11
Malaria	4	9
Military	2	9
Civilian	2	0
Meningococcal Meningitis	12	13
Mumps	158	417
German Measles	109	94
Measles	114	392
Salmonella	17	47
Shigella	14	12

Salmonella Outbreaks

Two outbreaks of salmonellosis arising from cross-contamination within a hospital were recently investigated.

In mid-February a one year old girl was admitted to a Bergen County hospital because of an upper respiratory infection. Two days later she developed diarrhea, cultures of which grew *Salmonella enteritidis*. The source of infection for this case was not determined. A one year old boy with tonsillitis was admitted on the same day and shared the same room. During his hospitalization, he developed mild diarrhea and once succeeded in partially removing his diaper and smearing semi-liquid feces over his crib and toys. The toys were rinsed off and brought home with the boy upon his discharge. Dried fecal material was subsequently noticed on the toys. Three days later he was readmitted to the hospital because of more severe diarrhea and was found to have infection with *Salmonella enteritidis*. During the subsequent week five family members and two of the neighbor's children developed salmonellosis due to the same serotype. A likely source of infection for all of these secondary cases was the grossly contaminated toys.

The second hospital related outbreak occurred in late March and early April on the pediatrics ward of a Passaic County hospital. The initial case was a 10 month old girl with asthmatic bronchitis. Within 12 hours of her admission she developed diarrhea and stool cultures were subsequently found to contain *Salmonella heidelberg*. It is probable that she was the source of introduction of salmonella into the hospital. Over the next two weeks five other children in two adjacent rooms developed gastroenteritis due to *Salmonella heidelberg*. Four of the five patients had had no gastrointestinal symptoms until several days after admission. None of the children had any epidemiologic association before admission. Since the children were infants and confined to their cribs, the hospital personnel probably spread the infection. A possible mode of spread was through hand-washing utilizing bars of soap and a paper towel dispenser which necessitated handling a metal crank.

According to the National Communicable Disease Center more than half of the hospital outbreaks of salmonellosis are due to person-to-person transmission. It is interesting that in both of the above outbreaks fomites (namely the toys and soap) were probably the vehicles that contributed to the person-to-person spread. The outbreaks emphasize the importance of scrupulous hygienic technic by hospital personnel caring for individuals with infectious disease.

Anthrax

The first case of anthrax occurring in a New Jersey resident since 1965 was recently investigated. The patient was a 45 year old man who worked part-time in a factory which produces gelatin from animal bones. In mid-March he appeared at work with a cut over his left eye which subsequently became infected. Cultures of the suppurative cellulitis revealed *B. anthracis*. The patient's job involved unloading animal bones purchased from foreign sources, usually India, South America or Africa, where anthrax is endemic. The unloading room was very dusty and pre-

viously environmental cultures of the area had grown *B. anthracis*. Because of the known hazard, workers were encouraged to wear protective masks. The patient failed to follow this advice. The bones are dumped into a caustic soda solution which kills the anthrax spores. The final product, therefore, is without infection risk.

PHYSICIANS SEEKING LOCATION IN NEW JERSEY

(Listed in order of receipt)

The following physicians have written to the Executive Offices of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly of them.

ANESTHESIOLOGY—Claude Magnant, M.D., 710 Zumbro Drive, NW, Rochester, Minnesota 55901. Temple, 1963. Board Eligible. Group or partnership. Available July 1969.

DERMATOLOGY—Charles Wasilewski, Jr., M.D., 205 Oak Street, Danville, Pennsylvania 17821. Jefferson, 1963. Board eligible. Multispecialty group. Available July 1969.

INTERNAL MEDICINE—David A. Berkowitz, M.D., 2408A Snark Street, Griffiss AFB, New York 13440. New York Medical, 1963, Board eligible. Group or partnership. Available July 1969.

David Lemper, M.D., 8700 West Wisconsin Avenue, Milwaukee, Wisconsin 53226. University of Pennsylvania, 1965. Subspecialty, nuclear medicine. Solo, group or partnership. Available July 1969.

Edward Lebowitz, M.D., 37 Saranac Avenue, Lake Placid, New York 12946. Downstate Medical Center (NYU), 1963. Board eligible. Subspecialty, diabetes and endocrinology. Group or partnership. Available June 1969.

OBSTETRICS AND GYNECOLOGY — Donald S. Cohen, M.D., 2512A Atlas Drive, Griffiss Air Force Base, New York, 13440. Columbia, 1962. Board certified. Partnership or group. Available July 1969.

Harold M. Yatvin, M.D., Kirk Army Hospital. Aberdeen Proving Ground, Aberdeen, Maryland 21001. New York Medical, 1962. Board eligible. Group. Available August 1969.

Jerry A. Wider, M.D., 315 Congressional Lane, Rockeville, Maryland 20852. Columbia, 1963. Board eligible. Partnership or Group. Available July 1969.

Ronald P. Portadin, M.D., 296-B Bizerte Road, Fort Lee, Virginia 23801. Georgetown, 1962. Board eligible. Associate. Available July 1969.

Louis V. Miller, M.D., 353 Rolling Hill Road, Elkins Park, Pennsylvania 19117. Ohio State, 1959. Board eligible. Group or partnership. Available July 1969

OPHTHALMOLOGY — Franklin L. Bocian, M.D., 54 Orange Street, Brooklyn, New York 11201. Downstate Medical Center (NYU), 1964. Solo or associate. Available July 1969.

ORTHOPEDICS—Seymour Einhorn, M.D., 2nd General Hospital, Box 24, APO 09180, New York. New York Medical, 1957. Board Certified. Partnership. Available September 1969.

PATHOLOGY—Martin Berman, 6309 Winner Avenue, Baltimore, Maryland 21215. Downstate Medical Center (NYU), 1961. Board certified. Group, partnership, institution. Available July 1969.

SURGERY—Teofilo Po, M.D., 5235 Post Road 2-C, Riverdale, New York 10471. University of Santo Tomas, Manila, 1958. Board certified. Solo or group. Available April 1969.

Malcolm H. Sawyer, M.D., HQ, 3rd Air Force, Box 1563, APO New York 09125. Northwestern, 1936. Board eligible. Industrial or administrative. Available September, 1969.

Warren X. Collmann, M.D., 77 Penn Drive, West Chester, Pennsylvania 19380. University of Pennsylvania. 1950. Board certified. Group, partnership, or solo. Available.

THORACIC—CARDIOVASCULAR SURGERY—John K. Garan, M.D., Medical College of Georgia, Augusta, Georgia 30902. University of Paris (France) Medical School, 1961. Partnership, Group, Associate. Available July 1969.

UROLOGY—Albert P. Tarasuk, M.D., 350 East 17th Street, New York, New York 10003. George Washington, 1964. Associate. Available July 1969.

Alfred R. Bozzo, M.D., 3106 Holly Street, Alexandria, Virginia 22305. Georgetown, 1962. Board eligible. Solo or partnership. Available July 1969.

Myron M. Smith, M.D., 1115 Sixth Street, SW, Minneapolis, Minnesota 55414. NYU (Downstate) 1962. Board Eligible. Partnership. Available July 1969.

Physicians Needed: USA

Some challenging medical and surgical opportunities are now available in Appalachia to the physician who wants an out-of-the-ordinary kind of practice. No one will get rich doing this work, but it will give a sense of accomplishment, of making a sound contribution to the total community, of showing the world that our profession is still dedicated to service, and an escape from routine. There are needs for general practitioners, surgeons and all kinds of specialists. For details, write to Project Director, Appalachian Health, Box 12038, Washington, D.C. 20005

They'll Ask Ann Landers

Ask Ann Landers. That's what 2,000 physicians' wives will be doing at the 46th Annual Convention of the Woman's Auxiliary to the American Medical Association, July 13 through 17, at the Waldorf Astoria in New York City.

Miss Landers, author of the world's most widely syndicated newspaper advice column and a member of the AMA's Advisory Committee on Health Care of the American People, will be one of the featured speakers at the convention. And on July 13, the Auxiliary will hold a reception for the president, Mrs. C. C. Long, Ozark, Arkansas, and president-elect, Mrs. John M. Chenault, Decatur, Alabama.

Dwight L. Wilbur, M.D., AMA President, will be the guest speaker at the July 14 luncheon. At this time Mrs. Long will present the Auxiliary's contribution to the American Medical Association Education and Research Foundation. Last year's gift totaled $389,824.

Another highlight will be a "Show and Tell" film, scheduled for Tuesday, July 15, from 2:30 to 4:30 p.m. State auxiliaries will be invited to display their projects and/or show films produced by or for them. This new feature is to provide auxiliary leaders with an interchange of ideas for initiating activities in their own communities.

As in previous years, a program of daily events for the preteens and teenagers of Auxiliary members will be held.

OBITUARIES

Dr. Martin M. Fischbein

His many friends were shocked on March 12, 1969 to learn of the unexpected death of Dr. Martin M. Fischbein, an Irvington internist. He was only 56 years old at the time of his death, which culminated an unusual life of community usefulness. He received his M.D. at Cincinnati in 1938. Dr. Fischbein had long been active in work with the police and other community agencies. He had a special interest in arthritis and rheumatology and was affiliated with the Irvington General Hospital.

Dr. Alfred F. Mezzetti

Alfred Mezzetti, M.D., a general practitioner, well-known in southern New Jersey, died on April 24, 1969. Dr. Mezzetti was active in the affairs of the Cumberland County Medical Society. He was a 1930 graduate of Hahnemann Medical College and was on the staff of the Newcomb Hospital in Vineland. He was 70 years old at the time of his death.

Dr. Joseph A. Rowe

Born in 1899, Joseph A. Rowe, M.D. was a graduate of the medical school of Georgetown University, class of 1928. He was an anesthesiologist who was affiliated with the Holy Name Hospital in Teaneck. He was a member — and formerly a very active one — of our Bergen County Medical Society, later becoming an emeritus member. Dr. Rowe practiced in River Edge and was 70 years old at the time of is death on March 12, 1969.

Dr. Charles H. deT. Shivers

And so, at the age of 82, Dr. Charles H. deTruck Shivers is dead! Born in 1887 (during Grover Cleveland's first presidential term), he received his M.D. degree at the medical school of the University of Pennsylvania in 1913 — before the rumblings of even the first World War. He served in that war, first as a lieutenant, then a captain, and then a major. He was a urologic surgeon in the days when that was a rare specialty, and he taught urology at the graduate medical school of the University of Pennsylvania. Dr. Shivers was active in (and, indeed, for a term was its president) our State's prestigious Society of Surgeons. For many decades, he was a key figure in the Atlantic County Medical Society.

BOOK REVIEWS

Growth of the Nervous System (Ciba Foundation Symposium). Edited by G. E. W. Wolstenholme and Ruth Porter. Boston, 1968, Little, Brown and Company. Pp. 295. With 101 Illustrations. ($12.00)

This is a small book when measured by its thickness and weight, but large when gauged by its content and depth. It explores the development of the nervous system in non-human embryos and the connections of nerves and the transmission impulses in man and other adult animals. Twenty-six biologic scientists were speakers and discussors in this symposium, coming from the four corners of the world. The presentation includes 15 papers, each followed by an 8 to 10 page discussion. The symposium is divided into four sections: (1) Development of Specific Neuronal Connections; (2) Development of Movement; (3) Role of Chemically Specific Signals in the Development of the Nervous System; and (4) Trophic Interaction, Peripheral and Central. Results of many methods are reported, including electron microscopy, radioactive tracers, neurochemistry and tissue transplantation.

According to its jacket, the book is recommended for reading and reference to "neurologists, neuro-anatomists, neurophysiologists, psychiatrists, and neurosurgeons." To these I would add, pathologists, internists, and all physicians interested in the progress of scientific medicine as it applies to the nervous system. This good book is highly recommended for these groups. Many of the discussions are worth several readings. The electron micrographs are excellent and informative.

HUGH F. LUDDECKE, M.D.

Current Therapy 1969. Edited by Howard F. Conn, MD. Philadelphia, 1969, Saunders. Pp 945. No illustrations, but many tabulations. ($15)

Differential diagnosis and basic physiology may be fascinating subjects, but in medical practice, treatment is what pays off. If the physician can't treat the patient effectively, the rest of his knowledge is but an academic exercise. As a guide to therapy, this book (now starting its third decade) is, and has been in its previous editions, a useful and usable road map. The authors are distinguished clinicians. Each new edition is practically a new book, since therapeutic methods necessarily undergo constant re-evaluations. Its all here, from the treatment of adbominal cramps and abruptio placentae, right down the alphabet to the treatment of xylol poisoning and the Zollinger Syndrome. (Look that one up yourself: I had to). The advice is solid, shorn of theoretical material and lean in its context. The book is further enriched by tables of normal laboratory values of clinical importance, by listings of available drugs (classified by dosage, form, efficacy, and side effects) by tabulations of tonicity with various parenteral solutions, and so on. Most of the material is presented in brisk 1, 2, 3 and 4 fashion which makes for swift reading and clarity of meaning. All told, this seems to be one of the most useful volumes available.

WILLIAM SCHRAM, M.D.

Instructions for Patients. H. Winter Griffith, M.D., Philadelphia, 1968. Saunders. Pp. 670 ($25)

My first impression on reading through this large, well written loose leaf tome, was that it appeared to be a waste of the reader's time. But, on giving the book some thought and after reflecting on my own experience, I came to feel that the manual could be utilized to advantage. It seems to me that these instructions would be used by the busy practitioner and would help organize the patient's thoughts about his condition as well as those of the doctor rendering therapy. Also, the very fact that the physician took the time to go over his instructions with the patient would help the latter both from a morale and a medical point of view. The manual contains individual instruction sheets, systematically arranged. Each condition is defined, important points in treatment listed and untoward symptoms mentioned so that the doctor would be notified. These instructions may be copied by the doctor on his office copier; but bulk copies must be obtained from a publishing house. Diets for many conditions are also supplied. The author has provided a comprehensive index. This book is recommended for review but not as a primary vehicle for the treatment.

EARL KANTER, M.D.

Married Love In The Middle Years. James A. Peterson, M.D. New York, 1968, Association Press. Pp. 156. ($4.95)

Having conquered in large measure those elements which threatened his survival, man has pursued relentlessly ways and means to perpetuate himself. During the twentieth century these efforts have been crowned with amazing success. Through natural and remarkably sophisticated artificial technics man has lengthened his life span. But because man lives longer, he is faced with a multitude of problems. He has not as yet learned to grow old gracefully. This serious and sensitive problem of growing old has even greater impact upon the married couple in their middle years. Dr. James A. Peterson attempts, in this book, to illuminate the "many aspects of adjustment problems . . ." which occur during the middle years and to ". . . meliorate some of the problems of the middle aged."

Regrettably, Dr. Peterson does not quite hit the mark and achieves only one-half of his avowed purpose. This is particularly unfortunate since Dr. Peterson brings to his subject most impressive credentials. An ordained minister, he is also a Professor of Sociology at the University of Southern California and executive secretary for a family center. Perhaps it is because of his marriage counseling experience that Dr. Peterson attempts the much too ambitious project of encompassing in one volume the whole gamut of emotional, psychological, physiologic, and sexual conflicts which arise within the structure of the aging marriage.

Leaning heavily on case histories which he and other marriage counselors have encountered, Dr. Peterson discusses in a clinical (and frequently repetitive) style such a wide variety of difficulties in the aging marriage as infancy, adolescent behavior patterns, courtship, child rearing and child launching, sexual achievement, retirement, health, and the contemplation of death. The author also devotes several pages to the generation gap between the middle-aged and teen-agers. In this area of faulty communication between the young and the middle-aged, there are common factors which Dr. Peterson might have explored to a greater extent. The youth, once he recognizes his existence, is en-

thralled with life and is at once appalled by the possible loss of it. With the realization that life is attractive and desirable, he attempts to avoid the awareness of death by seeking every distraction which might sublimate this reality.

The middle-aged couple, having raised their family and launched their children, are faced with a certain lack of purpose and the spectre of death without the distraction of youth. Dr. Peterson does point up the many constructive and productive activities which can be engaged in by the middle-aged married couple but does not offer any solace to the middle-aged man or woman who has no more mountains to climb or who has never had the opportunity to climb even one. It is perhaps this enthusiasm for the unattained goals that might be transmitted by the middle-aged to the young and spirited as a link between what has been and what might be.

As a text book exposition of married love in the middle years, marriage counselors and sociologists will find this book mildly rewarding. The less sophisticated middle-aged couple who are groping with the problems of the after-years will not find many new answers.

JOHN F. MERRIGAN, B.A.

A Manual of Simple Burial. Ernest Morgan. Burnsville, North Carolina, 1968, The Cello Press. Pp. 64 (Paperback—$1)

It is surprising how little most of us know about burials. Many physicians, indeed, don't even know how to advise patients with respect to bequeathing their bodies or specific organs to medical schools. This brief pamphlet brings all this information together, listing, for example, all the medical schools in the country and their emergency phone numbers. It reviews costs of funerals, the nature of memorial societies, the way to impart the fact of death to a child, the way you can rent films about funerals, the facts about cremation, the purchase of cemetery lots, and so on. The book is written with simplicity and dignity, as befits its topic. This modest but useful little book is a treasure house of information that most of us ought to have — but generally don't.

HENRY A. DAVIDSON, M.D.

Handbook of Pediatric Emergencies. Charles Varga, M.D. St. Louis, 1968, Mosby. Ed. 4. Pp. 694 ($19.75)

Pediatric textbooks like the cost of living get larger and larger. This book is no exception. It is no longer a handbook, and goes beyond the realm of pediatric emergencies. There has been a tremendous transition from the first to the present edition in a span of 17 years. The first edition could be carried in the side pocket of a jacket. The present edition is four times as large and fits best on a library shelf. A judicious removal of the fat would enhance the quality of the meat. The appendix contains an excellent section on accident prevention, but does it belong in a book dealing with emergencies? One might also question the value of the chapters dealing with anesthesia and psychiatry.

Aside from the excess baggage, this is an excellent book. Chapters dealing with newborn, cardiovascular, neurologic, respiratory, genitourinary, and metabolic emergencies are adequate and pertinent. The section on poisoning is comprehensive, but the list of poison control centers is incomplete. The chapter on pediatric procedures is the best I've seen anywhere. The text and the accompanying illustrations and photographs are extremely helpful especially to a physician who has had a skimpy training in pediatrics.

The inside of the front cover summarizes treatment for cardiac arrest and shock, and the inside of the back cover outlines the medical management of special emergencies, as well as the pages dealing with the specific problem. This makes for a rapid, easy reference. The format and type are an aid to easy reading.

ALBERT P. ROSEN, M.D.

Atlas of Precautionary Measures in Surgery. Ivan D. Baronofsky, M.D., St. Louis, 1968, Mosby. Pp. 281. With 111 plates and 132 figures ($23.50)

This atlas is a report on the prevention of complications of operative surgery in two dozen of the most common general surgical procedures. It is not a comprehensive surgical atlas and is not for the embryo or first year resident.

Here is a good review for the surgeon who should be aware of many of the complications of the operative technics described in this book. The cases selected are good ones, and the descriptions of the methods, complications, and precautionary measures to take in each operation, are clear and concise. They reflect the great operative experience of the author.

This is strictly a pictorial encyclopedia of technical operative problems and does not involve itself in diagnosis or pre and postoperative care. The illustrations are good in black and white and the schematic drawings are excellent.

The young and old-trained surgeon can benefit by reviewing this atlas prior to performing any of the procedures described in it.

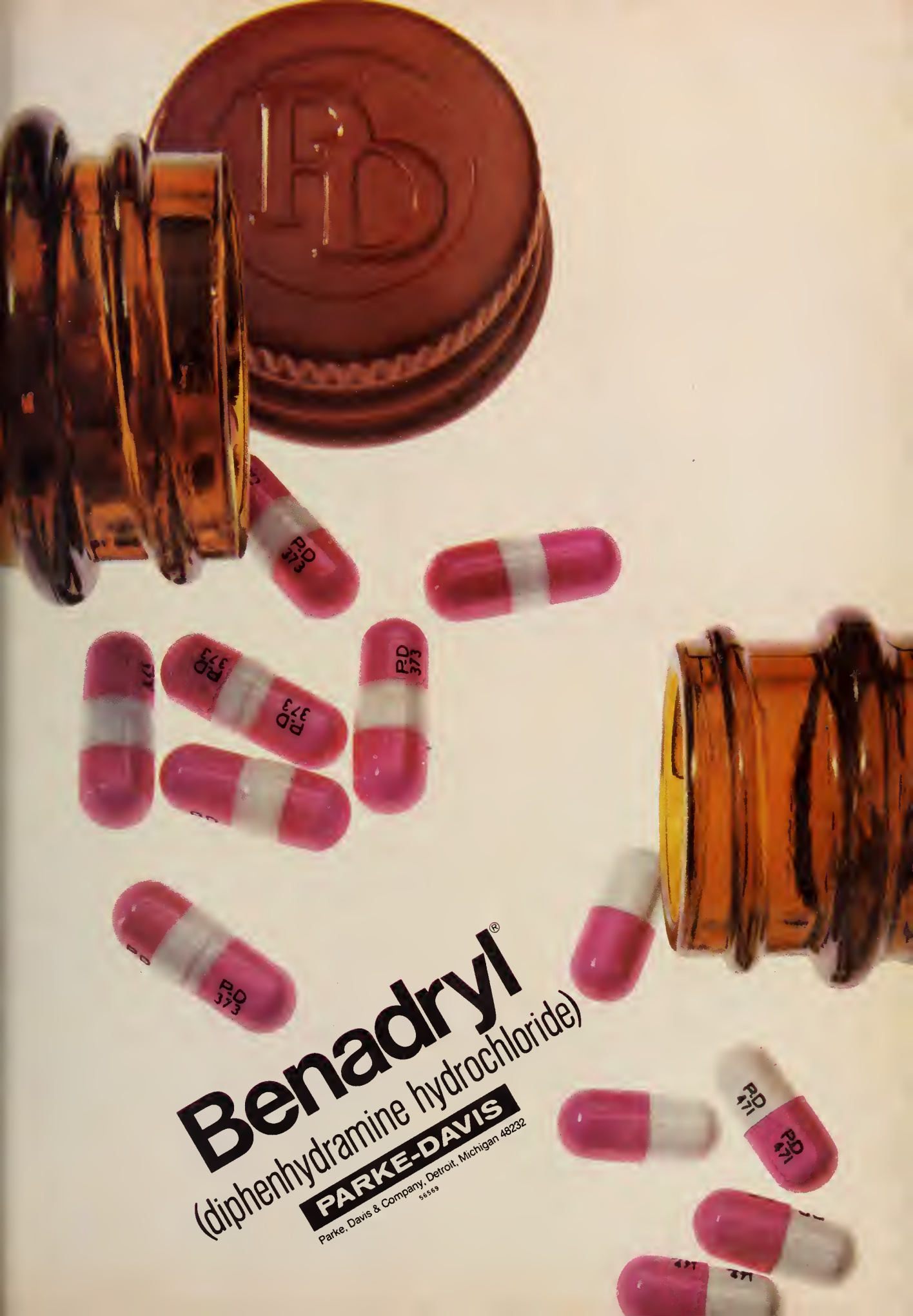
ROBERT E. RICH, M.D.

Atlas of Ear Surgery. William Saunders, M.D. and M. M. Paperella, M.D. St. Louis, 1968, Mosby. Pp. 363. With 163 Illustrations. ($27.50)

In a field of highly specialized, technical, and delicate surgery such as this, a clear, simple and accurate atlas of surgical technics provides an extremely valuable reference aid to the surgeon. This book is most useful in those terms. Certainly not a book for students or for physicians in general, this atlas is primarily for the otologist or the otolaryngology resident who is learning the newer otologic surgical methods. It starts with an interesting chronologic outline of the development of otology. This is followed by a detailed dissection of the temporal bone. A brief outline of the principles of preoperative, operative, and postoperative care precedes the main illustrative atlas of operative technics. Omitted are discussions of diagnosis and indications for surgery. This is intentional, as it is the desire of the authors to have the book used in conjunction with other otologic references.

Although the illustrations are in black and white, they have great clarity and are demonstrable and self-explanatory. Medical illustrator, Beverly Etter has done an excellent job. Such an undertaking cannot be all-inclusive nor totally complete, because of the rapidly changing field of otologic surgery. This atlas fills a needed place in the otologist's library, especially when one considers the uniqueness of microscopic ear surgery.

RAYMOND B. STRAUSS, M.D.


Benadryl®
(diphenhydramine hydrochloride)
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Parke, Davis & Company, Detroit, Michigan 48232
56569

The trouble with women...



frequently
is men

FLAGYL®
brand of metronidazole

Cures Trichomonal Infection in Both

Although *Trichomonas vaginalis* infection occurs in only 5 to 10 per cent* of men, careful diagnosis will demonstrate the condition in about half of all husbands of infected women. Nine investigators* reported an average incidence of 50.8 per cent in exposed consorts.

Many clinicians have achieved a high degree of success in treating trichomonal vaginitis only after they have recognized the importance of sexual partners in perpetuating the infection. Crowley* has asserted, "it was not until we acted on this key premise that we were able to obtain positive and lasting results in our management of recurrent vaginal trichomoniasis."

Simple ten-day oral treatment with Flagyl virtually assures elimination of established trichomonal infection in men. In twenty-two of twenty-seven studies* data on the results of treating male patients revealed that all men treated with Flagyl were cured.

Indications: Flagyl is indicated in the treatment of trichomoniasis in both men and women.

Contraindications: Pregnancy; disease of the central nervous system; evidence or history of blood dyscrasia.

Precaution: Complete blood cell counts should be made before, during and after therapy, especially if a second course is necessary.

Side Effects: Infrequent and minor side effects include nausea, metallic taste and furry tongue. Gastrointestinal disturbances, flushing and headache sometimes occur, especially with concomitant ingestion of alcohol. The taste of alcoholic beverages may be altered. Other effects, all reported in an incidence of less than 1 per cent, are diarrhea, dizziness, vaginal dryness and burning, dry mouth, rash, urticaria, gastritis, drowsiness, insomnia, pruritus, sore tongue, darkened urine, anorexia, vomiting, epigastric distress, dysuria, depression, vertigo, incoordination, ataxia, abdominal cramping, constipation, stomatitis, numbness or paresthesia of an extremity, joint pains, confusion, irritability, weakness, cystitis, pelvic pressure, dyspareunia, fever, polyuria, incontinence, decreased libido, nasal congestion, proctitis and pyuria. Elimination of trichomonads may aggravate candidiasis.

Dosage and Administration: *In women:* one 250-mg. oral tablet three times daily for ten days. A vaginal insert of 500 mg. is available for local therapy when desired. When used, one vaginal insert should be placed high in the vaginal vault each day for ten days; concurrently two oral tablets should be taken daily.

In men: When trichomonads are demonstrated, one 250-mg. oral tablet twice daily for ten days in conjunction with treatment of his female partner.

Dosage Forms: Oral tablets—250 mg.
Vaginal inserts—500 mg.

*Complete list of references on request.

SEARLE

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...now fast relief of hay fever symptoms with

NTZ®

Nasal Spray



When pollens fly, just one or two squirts of NTz in each nostril, followed in a few minutes by a second spraying, shrink swollen nasal passages almost on contact. And breathing comfort follows. The antihistamine component of NTz helps combat the allergic reaction and lessen rhinorrhea, sneezing and itching; its antiseptic wetting agent promotes rapid spread of components.

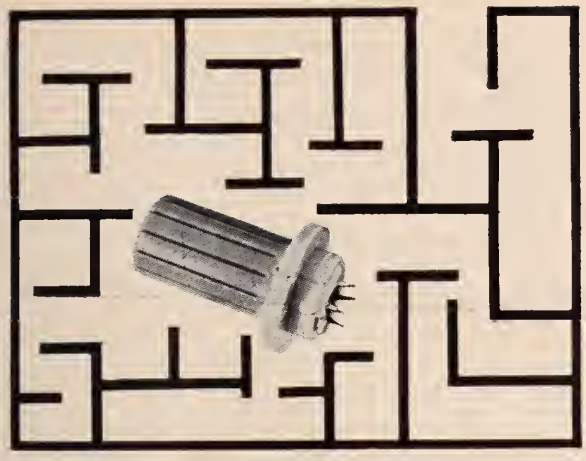
NTz Nasal Spray affords the well-known benefits of Neo-Synephrine® in a carefully balanced formula which includes:

Neo-Synephrine® (brand of phenylephrine) HC 0.5% (adult strength), decongestant
Thenfadil® (brand of thenyldiamine) HCl, 0.1% antihistamine
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Treatments with NTz should be repeated every thre or four hours as needed. NTz is for temporary relie of nasal symptoms and overdosage should b avoided. Available in squeeze bottles of 20 ml. an 1 oz. bottles with dropper.

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HISTO IS CONFUSING.

Histoplasmosis can mimic such unrelated diseases as TB, leukemia, pneumonia and syphilis. Use the blue Histoplasmin LEDERTINE™ Applicator as the first step in differential diagnosis and as a routine step in physical examinations for the permanent records of your patients.

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(Rosenthal)

Precautions—Nonspecific reactions are rare, but may occur. Vesiculation, ulceration or necrosis may occur at test site in highly sensitive persons. The test should be used with caution in patients known to be allergic to acacia, or to thimerosal (or other mercurial compounds).

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℞ **PAVACOT - T. D.**

(PAPAVERINE HCl.)

CLASS M NARCOTIC

Each Brown and Pink Capsule contains: Papaverine Hydrochloride . . . 150 mg. in a prepared base to provide prolonged action over an 8 to 12 hour period.

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because relief means so much to your G.U. patient



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URISED rapidly exerts spasmolytic action, relieving pain and discomfort of urgency, frequency, and burning on urination. Rapid acting URISED exerts antibacterial action against uropathogens susceptible to methenamine and methylene blue, in an acid medium.

URISED is safe . . . especially useful in long-term management of chronic cases; as a prophylactic measure with catheterization or after instrumentation. No systemic reactions or bacterial resistance have been reported.

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Each blue-coated tablet contains active:

Atropine Sulfate	.0.03 mg.	Methylene Blue	. . .5.4 mg.
Hyoscyamine	. . . .0.03 mg.	Phenyl Salicylate	.18.1 mg.
Methenamine	. . . .40.8 mg.	Benzoic Acid	. . . . .4.5 mg.

PRECAUTIONS: Administer with caution to persons with known idiosyncrasy to atropine or cardiac disease. While under this therapy the urine is blue; patients should be so advised to allay apprehension.

SIDE EFFECTS: Neither irritation nor other untoward reactions have been reported; however, if pronounced dryness of the mouth, flushing, or difficulty in initiating micturition occur, decrease dosage. If rapid pulse, dizziness, or blurring of vision occur, discontinue use immediately. Acute urinary retention may be precipitated in prostatic hypertrophy.

CONTRAINDICATIONS: Glaucoma, urinary bladder neck or pyloric obstruction, duodenal obstruction and cardiospasm. Hypersensitivity to any of the ingredients.

DOSAGE: Adults—Two tablets, orally, four times per day followed by liberal fluid intake. Acute cases—Initially two tablets every hour for three doses followed by the recommended daily administration. Children—One-half the adult dose.

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CONAL PHARMACEUTICALS, INC. CHICAGO, ILLINOIS 60640 / MANUFACTURERS OF URICEUTICAL® SPECIALTIES


It takes more than a pill
to lose weight

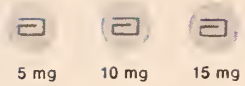
That's why Abbott's got what it takes–
a pill and a program for each patient

THE PRODUCT–5 Different Strengths

For smooth appetite control plus mood elevation

Desoxyn® Gradumet®

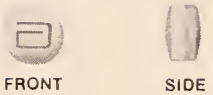
Methamphetamine Hydrochloride in Long-Release Dose Form



For patients who can't take plain amphetamine

Desbutal® 10 Gradumet

10 mg. Methamphetamine Hydrochloride, 60 mg. Sodium Pentobarbital



Desbutal 15 Gradumet

15 mg. Methamphetamine Hydrochloride, 90 mg. Sodium Pentobarbital



THE PROGRAM–3 Patient Booklets



Weight Control Booklet

Specifically written to help your patients understand why they are overweight, and what they can do about it. The booklet stresses the importance of *changing lifelong eating habits* and explains how this can be done, sensibly, comfortably —and permanently. Food exchanges and a comprehensive list of foods, showing their calories, are also included.



Food Diary

Designed to help the overweight patient follow your eating instructions. Space is provided for breakfast, lunch, supper, and even snacks. By writing down everything that's eaten each day, the patient is constantly reminded that she's trying to change her eating habits. And you are furnished with a written record of how well she's doing.



Picture Menu Booklet

Compact new booklet features appetizing lunch and dinner menus for every day of the week. The meals are depicted in full color and the correct portion size so that the dieter can see the amount of food that's recommended. Patients are pleasantly surprised to learn that each day's meals add up to only 1,000 calories.

902110

ABBOTT

Please see Brief Summary on next page.

Ask Your Abbott Man For Patient Supplies.

BRIEF SUMMARY

Desoxyn® Gradumet®
Methamphetamine Hydrochloride
in Long-Release Dose Form

Desbutal® 10 Gradumet
10 mg. Methamphetamine Hydrochloride,
60 mg. Sodium Pentobarbital

Desbutal 15 Gradumet
15 mg. Methamphetamine Hydrochloride,
90 mg. Sodium Pentobarbital

Indications: Desoxyn and Desbutal are used orally as appetite suppressants, for reduction of mild mental depression, and to help in management of psychosomatic complaints or neuroses. Desoxyn, when administered parenterally, may be used as a vasopressor agent or analeptic.

Contraindications: Methamphetamine (in Desoxyn and Desbutal) is contraindicated in patients taking a monoamine oxidase inhibitor. Do not use pentobarbital (in Desbutal) in persons hypersensitive to barbiturates, or in those with history of manifest or latent porphyria.

Precautions, Side Effects: Observe caution in patients with hypertension, cardiovascular disease, hyperthyroidism, old age, or those sensitive to sympathomimetic drugs. Prolonged usage may lead to tolerance or psychic dependence. Careful supervision is necessary to avoid chronic intoxication and drug dependence.

Amphetamine side effects such as headache, excitement, agitation, palpitation or cardiac arrhythmia usually may be controlled by reducing the dose. Paradoxically-induced depression is an indication to withdraw the drug. Because of its sodium pentobarbital content, use Desbutal with caution in patients receiving coumarin anticoagulants. Pentobarbital may cause skin rash. Nervousness or excessive sedation with Desbutal is often transient.

902110

ABBOTT

Achromycin V
250 mg. capsules

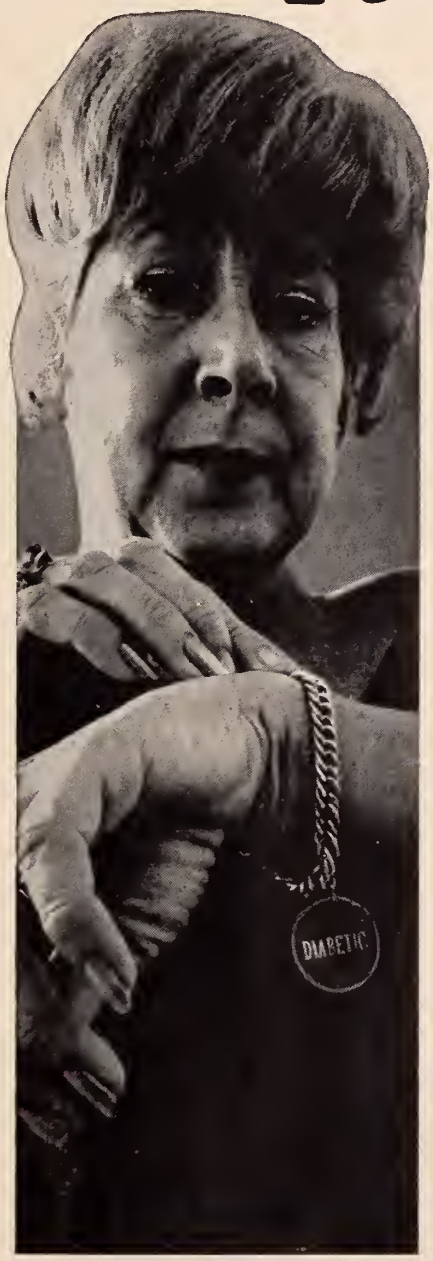
ACHROMYCIN® V
TETRACYCLINE HCl

Lederle

451C-9

a broad-spectrum antibiotic for the diabetic:

threat or therapy?



Disordered metabolism makes her prone to bacterial infection —and to moniliasis.

When she needs tetracycline, she may also need protection against the threat of fungal overgrowth. And Tetrex-F can provide both.

Each capsule contains 250 mg. of tetracycline phosphate complex to control sensitive bacterial pathogens...and nystatin, 250,000 units, as a precautionary measure against troublesome vaginitis, proctitis or other monilial infections. However, superinfection with other, nonsusceptible organisms may occur.

Tetrex-F®

(tetracycline phosphate complex-nystatin)

PRESCRIBING INFORMATION: Tet-F. 5—2/23/67. For complete information consult Official Package Circular.

Indications: Infections of respiratory, gastrointestinal and genitourinary tracts and skin and soft tissues due to tetracycline-sensitive organisms, in patients with increased susceptibility to monilial infections.

Contraindications: The drug is contraindicated in patients hypersensitive to its components.

Warnings: Photodynamic reactions have been produced by tetracyclines. Natural and artificial sunlight should be avoided during therapy. Stop treatment if skin discomfort occurs. With renal impairment, systemic accumulation and hepatotoxicity may occur. In this situation, lower doses should be used. Tooth staining and enamel hypoplasia may be induced during tooth development (last trimester of pregnancy, neonatal period and childhood).

Precautions: Bacterial superinfections may occur. Infants may develop increased intracranial pressure with bulging fontanels. In gonorrheal therapy, serologic tests for syphilis should be conducted initially and monthly for 3 months.

Adverse Reactions: Glossitis, stomatitis, nausea, diarrhea, flatulence, proctitis, vaginitis, dermatitis, and allergic reactions may occur.

Usual Adult Dosage: 1 capsule q.i.d. Continue for 10 days in Beta-hemolytic streptococcal infections. Administer one hour before or two hours after meals.

Supplied: Capsules, bottles of 16 and 100. Each capsule contains tetracycline phosphate complex equivalent to 250 mg. tetracycline HCl activity and 250,000 units of nystatin.

For Oral Suspension, 125 mg. tetracycline and 125,000 u. nystatin/5 ml., 60 ml. bottles. **A.H.F.S. Category 8:12**

BRISTOL

BRISTOL LABORATORIES
Division of Bristol-Myers Company
Syracuse, New York 13201

But before you prescribe Pertofrane, please see the full prescribing information and especially note Contraindications, Precautions, Warning, Adverse Reactions and Dosage. A brief summary of that information is included here.

Pertofrane® desipramine hydrochloride

Indications: For relief of depression.
Contraindications: Do not use drugs of the M.A.O.I. class with Pertofrane. Hyperpyretic crises or severe convulsive seizures may occur; potentiation of adverse effects can be serious or even fatal. When substituting this drug in patients receiving an M.A.O.I., allow an interval of at least 7 days. Initial dosage in such patients should be low and increases should be gradual and cautiously prescribed.
Warning: Activation of psychosis may occasionally be observed in schizophrenic patients. Do not use in patients under 12 years old, and do not use in women who are or may become pregnant unless the clinical situation warrants the potential risk.
Precautions: Careful supervision and protective measures for potentially suicidal patients are necessary. Discontinuation of therapy or adjunctive use of a sedative or tranquilizer may be necessary in the presence of increased anxiety or agitation, hypomania or manic excitement. However, phenothiazines may aggravate the condition. Atropine-like effects may be more pronounced (e.g. paralytic ileus) in susceptible patients and in those receiving anticholinergic drugs (including antiparkinsonism agents). Carefully observe patients with increased intraocular pressure. Prescribe cautiously in hyperthyroid patients and in those receiving thyroid medications. Cardiovascular complications (myocardial infarction and arrhythmias) are potential risks since they have occasionally occurred with imipramine, the parent compound. Desipramine may block the pharmacologic activity of guanethidine and related adrenergic neuron-blocking agents. Hypertensive episodes have been observed during surgery in patients on desipramine therapy.
Before prescribing the drug, the physician should be thoroughly familiar with prescribing information, with the literature, with all adverse reactions, with the diagnosis and management of depression, and with the relative merits of all measures for treating the condition.
Adverse Reactions: Dry mouth, constipation, disturbed visual accommodation, anorexia, perspiration, insomnia, drowsiness, dizziness, headache, nausea, epigastric distress, and skin rash (including photosensitization) may appear. Since orthostatic hypotension has occurred, carefully observe patients requiring concomitant vasodilating therapy, particularly during the initial phases. Other adverse reactions include tachycardia, changes in EEG patterns, tremor, falling, mild extrapyramidal activity, neuromuscular incoordination, epileptiform seizures. A confusional state (with such symptoms as hallucinations and disorientation) occurs occasionally and may require reduced dosage or discontinuance of therapy. Rarely, transient eosinophilia, slight elevation in transaminase levels, transient jaundice, or liver damage have occurred. If abnormalities occur in liver function tests, discontinue drug and investigate. Occasional hormonal effects, particularly decreased libido or impotence and instances of gynecomastia, galactorrhea and female breast enlargement have been observed. Urinary frequency or retention may occur. The drug should be discontinued if agranulocytosis, bone marrow depression, jaundice, thrombocytopenia, or purpura occur.
Dosage: 25 to 50 mg. t.i.d. The maximum daily dose is 200 mg. Continue maintenance dosage for at least 2 months after obtaining satisfactory response. Generally, elderly and adolescent patients should be given low doses.
Availability: Pink capsules of 25 mg in bottles of 100 and 1000 (B) 46-530-E

For complete details, please see the prescribing information.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
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What makes a

A man?
Another woman?
Three kids?
No kids at all?
Wrinkles?
You name it.

Is she truly depressed?

Is that why she lets go in your office?

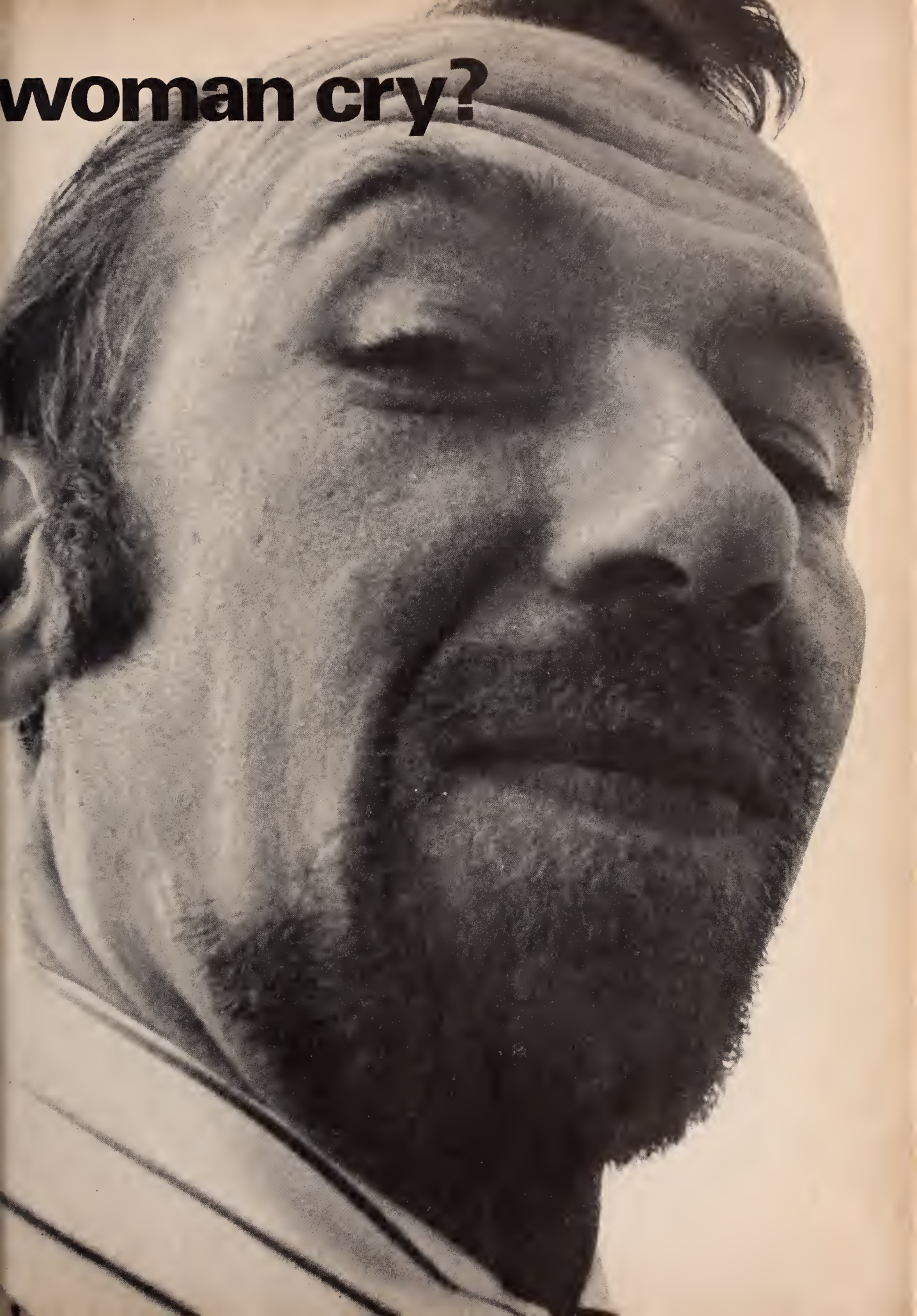
You comfort her.
Talk to her.
And, if she is depressed, consider Pertofrane.
Because
in 3 to 5 days
she can often begin
to cope,
work,
maybe play,
even enjoy.

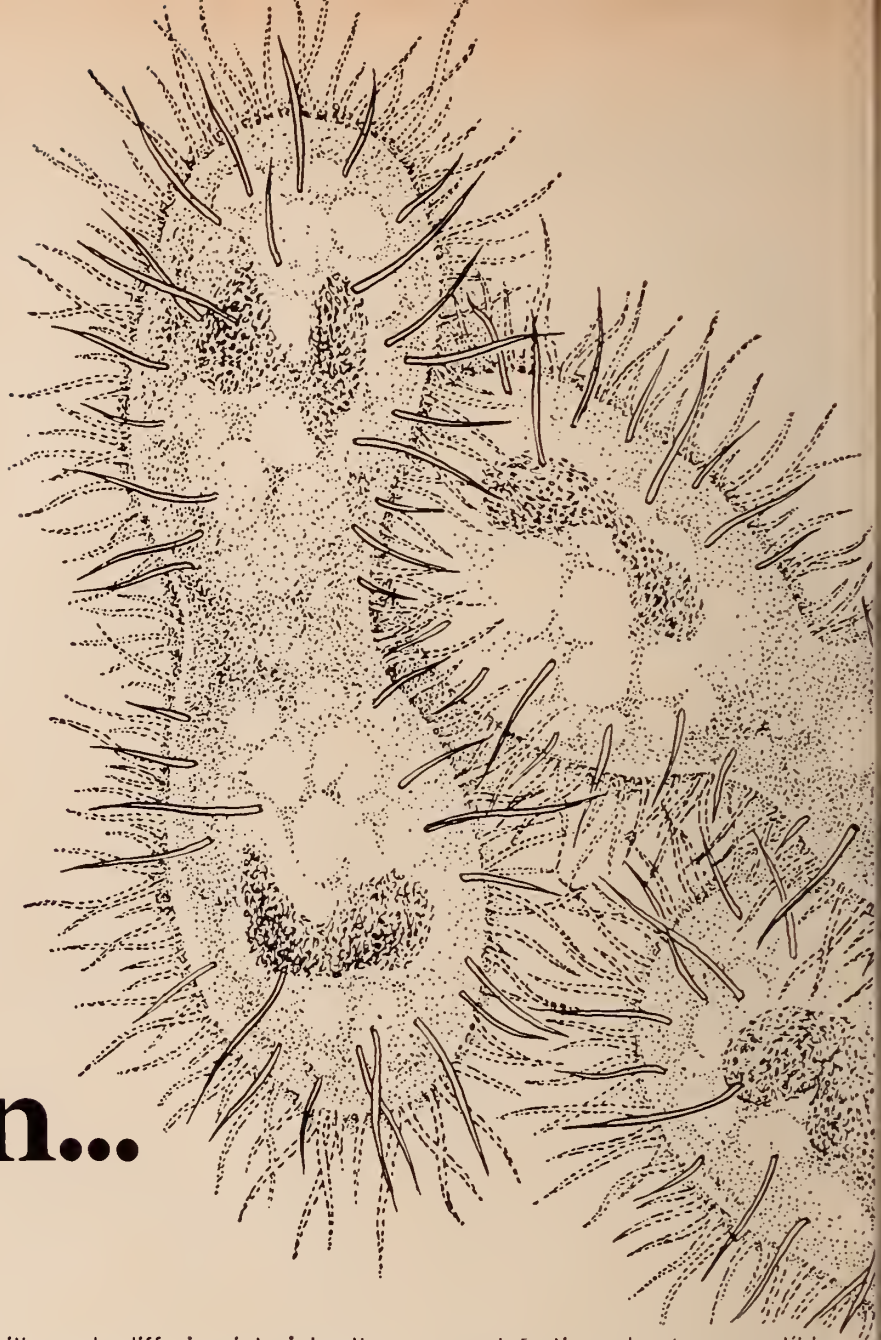
Pertofrane®

desipramine hydrochlorid

In depression...
when words are not enou

woman cry?





A high index of suspicion... E. coli

How high is the "index of suspicion" for *E. coli* in urinary tract infections?

Recently it has been estimated that about 86 per cent of positive cultures in first attacks of urinary tract infection are *E. coli*.[1] It has also been noted that "The coliform group, especially *E. coli*, accounts for approximately 90 per cent of initial infections...."[2]

Consider wide-spectrum Gantanol® (sulfamethoxazole) for its high "index of confidence"—its proven effectiveness against *E. coli* and other sensitive gram-negative and gram-positive organisms. Therapeutic levels of Gantanol in blood and urine are achieved within 2 hours after a 2-Gm starting dose, with ready diffusion into interstitial fluids. Responsive infections generally clear within 5 to 7 days, with relief of symptoms usually seen within 24-48 hours.

Gantanol also earns its high "index of confidence" because Gantanol therapy is relatively free from complications, including the problem of bacterial resistance or superinfection.

Convenient, economical dosage schedule: *b.i.d.*

References: 1. Vernier, R. L., in Patient Care Feature: *Patient Care, 1*:20 (Feb.) 1967. **2.** Beeson, P. B.: "The Infectious Diseases," in Beeson, P. B., and McDermott, W. (eds.): *Cecil-Loeb Textbook of Medicine*, ed. 12, Philadelphia, W. B. Saunders Company, 1967, p. 230.

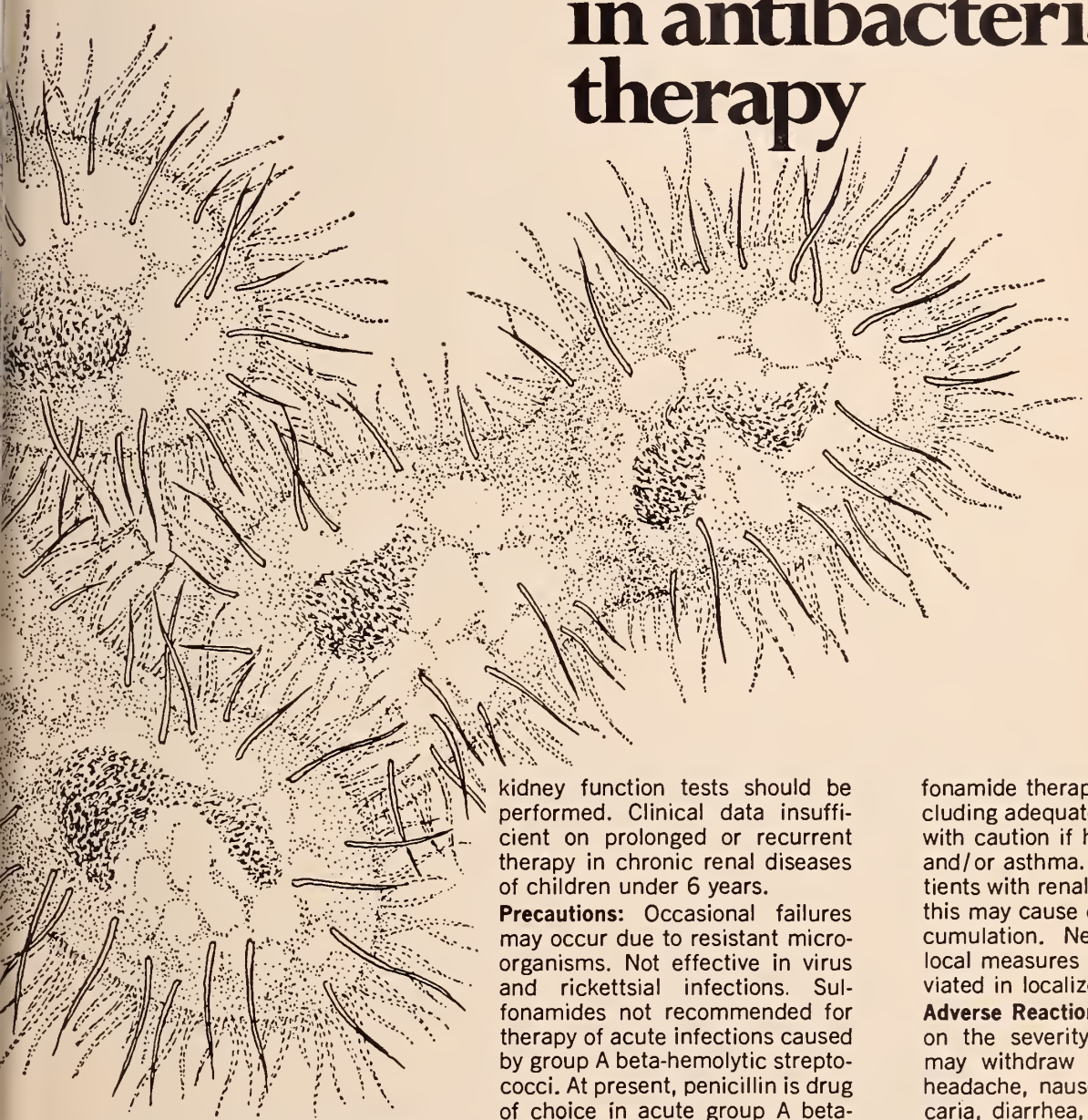
Before prescribing, please consult complete product information, a summary of which follows:

Indications: Acute and chronic urinary tract, respiratory and soft tissue infections due to susceptible microorganisms; prophylactically following diagnostic instrumental procedures on genitourinary tract.

Contraindicated in sulfonamide-sensitive patients, pregnant females at term, premature infants, or newborn infants during first 3 months of life.

Warnings: Use only after critical appraisal in patients with liver or renal damage, urinary obstruction or blood dyscrasias. Deaths reported from hypersensitivity reactions, Stevens-Johnson syndrome, agranulocytosis, aplastic anemia and other blood dyscrasias. In closely intermittent or prolonged therapy, blood counts and liver and

For a high index of confidence... Gantanol® (sulfamethoxazole) in antibacterial therapy



Artist's rendition of E. coli. As with most strains of E. coli, these have flagella and are motile.

kidney function tests should be performed. Clinical data insufficient on prolonged or recurrent therapy in chronic renal diseases of children under 6 years.

Precautions: Occasional failures may occur due to resistant microorganisms. Not effective in virus and rickettsial infections. Sulfonamides not recommended for therapy of acute infections caused by group A beta-hemolytic streptococci. At present, penicillin is drug of choice in acute group A beta-hemolytic streptococcal infections; although Gantanol has produced favorable bacteriologic conversion rates in this infection, data insufficient on long-term follow-up studies as to its effect on sequelae of rheumatic fever or acute glomerulonephritis. If other treatment cannot be used and Gantanol is employed in such infections, *important that therapy be continued in usual recommended dosage for at least 10 days.* Observe usual sulfonamide therapy precautions, including adequate fluid intake. Use with caution if history of allergies and/or asthma. Follow closely patients with renal impairment since this may cause excessive drug accumulation. Need for indicated local measures or surgery not obviated in localized infections.

Adverse Reactions: Depending upon the severity of the reaction, may withdraw drug in event of headache, nausea, vomiting, urticaria, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, Stevens-Johnson syndrome, skin rash, injection of the conjunctiva and sclera, petechiae, purpura, hematuria and crystalluria.

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in the treatment of

IMPOTENCE



Android®

(thyroid-androgen) TABLETS

*Effectiveness confirmed by another double blind study**

1. SUMMARY

ANDROID	GOOD TO EXCELLENT 75%
PLACEBO	20%

2. Forty cases reported.
3. Cites synergism between androgen and thyroid.
4. No side effects in patients treated.
5. Alleviation of fatigue noted
6. Case histories on 4 patients.
7. Although psychotherapy still needed, role of chemotherapy cannot be disputed.

*"Sexual impotence treatment with methyl testosterone – thyroid (ANDROID) a double blind study" – Montesano, Evangelista: Clinical Medicine, April 1966.

CONTRAINDICATIONS—Methyl testosterone is not to be used in malignancy of reproductive organs in male, coronary heart disease. Thyroid is not to be used in heart disease, hypertension unless the metabolic rate is low.

Choice of 4 strengths

Android

Each yellow tablet contains:
Methyl Testosterone ..2.5 mg.
Thyroid Ext. (1/6 gr.) ..10 mg.
Glutamic Acid .....50 mg.
Thiamine HCL .....10 mg.
Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000.

Android-HP

HIGH POTENCY

Each red tablet contains:
Methyl Testosterone ..5.0 mg.
Thyroid Ext. (½ gr.) ...30 mg.
Glutamic Acid .....50 mg.
Thiamine HCL .....10 mg.
Dose: 1 tablet 3 times daily.
Available:
Bottles of 100, 500, 1000.

Android-X

EXTRA HIGH POTENCY

Each orange tablet contains:
Methyl Testosterone .12.5 mg.
Thyroid Ext. (1 gr.) ....64 mg.
Glutamic Acid .....50 mg.
Thiamine HCL .....10 mg.
Dose: 1 or 2 tablets daily.
Available:
Bottles of 60, 500.

REFER TO PDR

Android-Plus

WITH HIGH POTENCY B-COMPLEX AND VITAMIN C

Each white tablet contains:
Methyl Testosterone ..2.5 mg.
Thyroid Ext. (¼ gr.) ...15 mg.
Ascorbic Acid (Vit. C) .250 mg.
Thiamine HCL .....25 mg.
Glutamic Acid .....100 mg.
Pyridoxine HCL .....5 mg.
Niacinamide .....75 mg.
Calcium Pantothenate .10 mg.
Vitamin B-12 .....2.5 mcg.
Riboflavin .....5 mg.
Dose: 2 tablet twice daily.
Available: Bottles of 60, 500.

Write for literature and samples:

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2500 W. 6th St., Los Angeles, Calif. 90057

also available with ESTROGEN

Android-E

Each Tablet Contains:
Methyl Testosterone ..... 2.5 mg.
Ethinyl Estradiol ..... 0.02 mg.
Thyroid Ext. (1/6 gr.) ..... 10 mg.
Thiamine Hydrochloride .... 10 mg.
Glutamic Acid ..... 50 mg.

INDICATIONS: Advantage is taken of the anabolic action of ANDROID without its virilizing effect. Estrogen balances the androgen—only steroid effect remains. Geriatrics, post-operative and debilitating disease, osteoporosis. **DOSE**: One tablet t.i.d. Female patients should have a rest period 5 to 7 days after 21 days of medication. **SIDE EFFECTS**: In the female, excessive dosage may produce virilizing effects of most androgens. hoarseness, hirsutism, enlarged clitoris. Symptoms can be avoided by keeping the dosage below 300 mg. of testosterone per month. **CONTRA-INDICATIONS**: See Android. Ethinyl estradiol is not to be used in latent malignancy of reproductive organs or mammary glands.

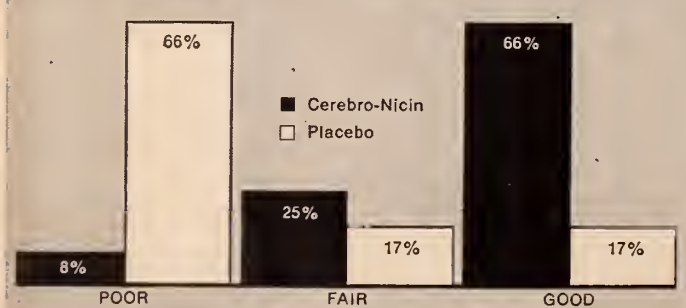
For the treatment of the aging patient

apathy
irritability
forgetfulness
confusion

Cerebro-Nicin®

capsules/elixir

A Gentle Cerebral Stimulant and Vasodilator



CEREBRO-NICIN® New double-blind study* shows how effectively senility can be forestalled. Four times as many aging patients showed striking improvement.

*A Double-Blind Study of Cerebro-Nicin, Therapy for the Geriatric Patient, R. Goldberg Jrnl,. of the Amer. Ger. Soc. June, 1964

Available in a tasty wine base elixir and capsules

Each Cerebro-Nicin capsule contains:

Pentylenetetrazole	100 mg.
Nicotinic Acid	100 mg.
Ascorbic Acid	100 mg.
Thiamine HCl	25 mg.
l-Glutamic Acid	50 mg.
Niacinamide	5 mg.
Riboflavin	2 mg.
Pyridoxine	3 mg.

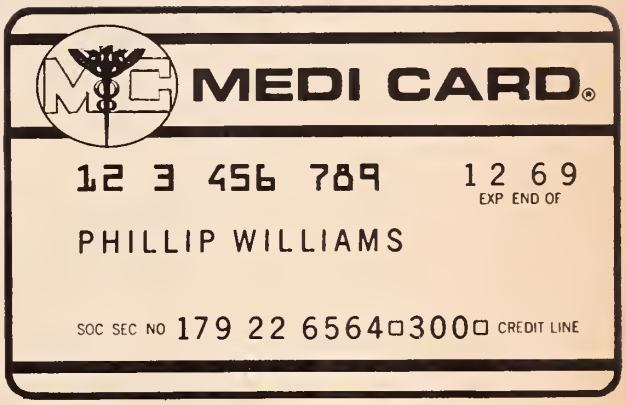
DOSAGE: One capsule t.i.d. or as prescribed by physician.
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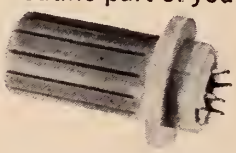
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UP BRITANNIA!

Recent announcement that the British United Provident Association (BUPA) has become an affiliate of the National Association of Blue Shield Plans brings some interesting information to light and recalls many memories.

For more than twenty-five years critics of the American system of medical care have been constantly predicting the end of private practice, and that the United States would adopt national health insurance. Some of our younger physicians seem to think today that Wagner, Murray and Dingell were the names of an old and famous double-play combination of the Pittsburgh Pirates Baseball Team. A small minority of physicians then, as today, argued "why bother to back Blue Shield—Congress will soon socialize medicine anyway".

Despite the few critics, the great majority of physicians have backed Blue Shield, made it work, and preserved private practice—and now our British cousins are taking a second look.

We all know that Britain has a National Health Service, tax-supported and available to all citizens. Would you believe that despite this, some 2 million Britons prefer to pay out of their own pockets for their health care insurance, with free choice of physician and hospital —and this in a country with a less than flourishing economy?

BUPA, by far the largest of the British prepayment plans, has 1.5 million members, about half the size of the New Jersey Blue Shield. It covers the complete spectrum of health care—physicians, hospitals, nursing homes—and has built a chain of hospitals to serve its subscribers.

Why would a British citizen, entitled to 'free' health care from his government, want to pay for a private plan?

According to Eric D. Roberts, General Manager of BUPA, "Private medicine will continue to grow in Great Britain because many people are attracted by its advantages.

'They like the freedom of choice of both the doctor and the place where the treatment is received, the privacy enjoyed, the absence of formal visiting hours and the speed of treatment, all inhibiting factors under the national system."

Mr. Roberts puts it tactfully; for "privacy' you might read 'satisfying doctor-patient relationship," and for "speed of treatment", "quality medical care."

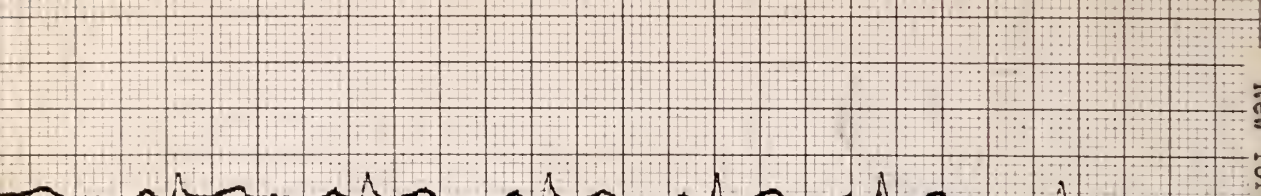
It's encouraging to note that even a nationalized health service cannot stifle the preference of millions to pay for medicine practiced under the free enterprise system. Medical-Surgical Plan of New Jersey tips its bowler to BUPA, its British cousin in the Blue Shield family.

Joseph Patrick Donnelly, M.D.

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Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms have occurred following abrupt discontinuance. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation, have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.



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